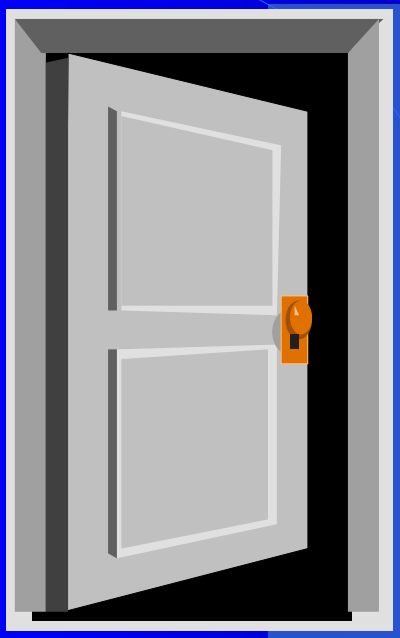
Division of MRDD-Eastern District of Missouri

LET'S GET MOVING



Opening doors to a new life

St. Louis Developmental Disabilities Treatment Center

Bellefontaine Habilitation Center

St. Louis Regional Center

4th Edition August, 2005

Community Transition Guidebook

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Letter of Acknowledgement

Many thanks go out to all the people who helped make the Community Transition Guidebook a reality. We first need to acknowledge Tennessee Department of Mental Health and Developmental Disabilities for sharing their community transition material and experience with us.

We would like to thank all the employees at St. Louis Regional Center, St. Louis Developmental Disabilities Treatment Center and Bellefontaine Habilitation Center who offered their community transition experience and expertise with us.

This guidebook is one more effort, among many dedicated employees, in fulfilling the mission and vision of Missouri Department of Mental Health.

MISSION STATEMENT

Working to develop partnerships that support opportunities, choices and community membership.

VISION: LIVES BEYOND LIMITATIONS

Missourians shall be free to live their lives and pursue their dreams beyond the limitations of mental illness, developmental disabilities, and alcohol and other drug abuse.

The Olmstead Fact Sheet

ASSURING ACCESS TO COMMUNITY LIVING FOR THE DISABLED (U.S. Supreme Court Olmstead v. L.C. Ruling)

On June 22, 1999, the U.S. Supreme Court affirmed through its Olmstead v. L.C. ruling that under the Americans With Disabilities Act (ADA) unjustifiable institutionalization of a person with a disability is discrimination when the treating provider believes that community-based care is appropriate and safe; when the affected person does not oppose the community-based option; and when the placement can be reasonably accommodated taking into account the resources available to the state and the needs of others. The court, in the ruling, determined that institutionalization severely limits a person's ability to interact with family and friends, to work, and to make a life for him or herself.

The Olmstead case was brought by two Georgia women with dual diagnoses (developmental disability and mental illness). At the time the suit was filed, both women were receiving mental health services in a state-run institution (inpatient psychiatric hospital), despite the fact that state treatment professionals had evaluated each as capable of being appropriately served in a community-based setting.

The Olmstead Decision

The Court based its ruling in Olmstead on Title II of the ADA, which pertains to Public Services. Section 12132 of Title II states:
"...no qualified individual with a disability shall, by reason of his disability, be excluded from participation in, or be denied benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity."
Federal Regulations define forms of discrimination prohibited under the ADA. This regulation {28 CFR Section 35.130(d)} is commonly referred to as "the integration mandate":
A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
The U.S. Department of Justice has defined *most integrated setting* as "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."

Certain principles have emerged from the Court's ruling:

- unjustified institutionalization of people with disabilities is discrimination and violates the ADA;
- states are required to provide community-based services for persons with disabilities otherwise entitled to institutional services when the state's treatment professionals reasonably determine that: a) community-based care is appropriate, b) the person does not oppose such placement, and c) the placement can reasonably be accommodated, taking into account resources available to the state and the needs of others receiving state-supported disability services;
- a person cannot be denied community services just to keep an institution at its full capacity; and,
- the ADA does not require that community-based services be imposed on people with disabilities who do not desire it.

The court also held that states are obliged to "make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity." Meeting the fundamental alteration test takes into account three factors:

1. the cost of providing services in the most integrated setting;
2. the resources available to the state; and
3. how the provision of services affects the ability of the state to meet the needs of others with disabilities.

Olmstead and the Medicaid Program

Olmstead is not a case about Medicaid. Nothing in the decision changes the basic nature of the Medicaid program or alters the structure of the individual entitlement or state obligations under the law. However, because Medicaid comprises such a large proportion of state health expenditures in the area of long-term care, Olmstead is causing the state to focus even more extensively on its Medicaid policy and program choices regarding long-term care, both in institutions and in the community. Any alterations to the state's Medicaid policies should be thought of as a consequence of, rather than required by, the Olmstead decision.

Because the Medicaid program is such a critical resource to states in funding long-term care, the Health Care Financing Administration (HCFA) has been issuing information related to the Olmstead decision to states. For example, HCFA has reminded states that it (HCFA) has the obligation under Medicaid to periodically review the services of all residents in Medicaid-funded institutions and is reviewing how clarification or changes in their policies can help states to strengthen community services. In the court's ruling, HCFA

suggested that a state may be able to meet its obligation under the ADA by demonstrating that it has a comprehensive, effectively working plan for providing services to persons with disabilities in integrated settings and a waiting list that moves at a reasonable pace. Although nothing in the ruling requires a state to have such a plan, both HCFA and Office of Civil Rights are strongly encouraging states to develop plans and are offering technical assistance in doing so.

Missouri Action

Governor Mel Carnahan issued an executive order creating the Home and Community-Based Services and Consumer-Directed Care Commission. The objective of the commission is to develop a comprehensive, effectively working plan, as recommended by the U.S. Supreme Court in its Olmstead decision. The commission is required to submit a working plan to the governor by December 31, 2000. To read the executive order, go to:

http://www.sos.state.mo.us/library/reference/orders/2000/eo00_009.asp

* The Health Care Financing Administration (HCFA) is now called Center for Medicaid and Medicare Services.

COMMUNITY TRANSITION
GUIDE

The Community Transition Guide is intended to provide the team of an individual (consumer), considering transitioning, with basic information about the transition process and what they may expect to occur. Transition is the process by which a consumer, currently living in a Habilitation Center, moves to the community. It starts with the decision by the consumer, with assistance from his/her family, friends, and guardian to move into his/her own chosen home in the community. This decision is documented through a letter that is sent to the consumer's guardian, by a member of the consumer's multidisciplinary team, authorizing the habilitation center to initiate the "Community Placement Options" referral process ***(Appendix A - "Community Placement Options letter").*** Included in the letter is a request to complete a survey that will ensure that the transition process promotes opportunity, choice and community membership ***(Appendix B – "Needs and Preference Survey")***

Choices:

Persons with mental retardation or other developmental disabilities, with the support of their family and friends, should be able to make their own decisions about their lives. Their choices will be part of the dreams and vision they have for the future. The choices made will depend on their likes and dislikes in all aspects of life including home, work, and recreation. When given a choice, each person would choose an ordinary life. Some specific choices that will need to be made during the transition process include:

- Where do I want to live?
- Who do I want to live with, if anyone?
- What kind of work or other day activity would I like?
- What kind of social and recreational activities do I want to engage in and how much money will I need to do it?
- Which provider agency will provide residential supports and which agency will provide day supports.
- What medical/behavioral support will I need to have in place when I move to the community?
- Which agency do I want to provide service coordination?
- How much family contact do I want and how will that occur?
- What new relationships do I want to develop in the community in which I will live?
- What relationships from my present do I want to keep?
- What relationships from my past do I want to reconnect with?

The Department of Mental Health -Eastern District serves St. Louis County, St. Louis City, Jefferson County & St. Charles County. Individuals in these offices, along with staff at the Habilitation Centers, will assist the consumer and his/her guardian as decisions are made throughout the Transition Process by providing information about available resources and opportunities in the community. All will work together to make the consumer's choice for an ordinary life come true ***(Appendixes C – "MRDD Facility Map"; D – "MRDD Regional Center Listing"; & E "Case Assignment").***

In order to make informed choices, consumers and their families need as much information as possible about options available to them, as well as understanding the differences between living at a habilitation center vs. in the community. Community living is an option. What is important to remember is that an individual's needs must be considered in the decision on where one should reside.

Community Living

- **Home & Community Based Waiver**
  - **Meets eligibility criteria for the Comprehensive Waiver**

The MRDD Comprehensive Waiver is one of the three waivers administered by the Missouri Department of Mental Health's Division of Mental Retardation and Developmental Disabilities (DMRDD) 1915(c) Home and Community Based Medicaid Waiver programs for individuals with mental retardation or other developmental disabilities

Authority for 1915(c) waivers is the result of a special arrangement between the state and federal government that allows the state to use Medicaid funding for specialized services provided only to a target group of people and not to all people with Medicaid eligibility. The state determines the number of people it will serve, what services it will cover, and how much it will spend on waiver services. Medicaid funding in Missouri consists of matching 40 percent state tax dollars with 60 percent federal dollars.

What services are available through the MRDD Comprehensive Waiver?

MRDD WAIVER (COMPREHENSIVE WAIVER)
Day habilitation
Respite
Personal assistant
Crisis intervention
Community specialist
Environment accessibility adaptations (Home modification)
Specialized medical equipment and Supplies (Adaptive equipment)
Behavior therapy
Transportation
Residential habilitation
Individualized supported living
Communication skills instruction
Occupational therapy
Speech therapy
Physical therapy
Counseling
Supported employment

Who qualifies for the MRDD Comprehensive Waiver?

- Eligible for Medicaid as determined by the Missouri Department of Social Services' Division of Family Services under an eligibility category that provides for Federal Financial Participation (FFP) and is not an "expanded" eligibility category under the 1115 Waiver.

- Determined by the DMRDD Regional Center initially and annually thereafter to require an ICF/MR level of care if waiver services are not provided. The ICF/MR level of care requires that an individual have mental retardation or a related condition as defined in federal rule (42 CFR 435.1009), plus a need for the level of care provided in an ICF/ MR. In addition, it requires a determination that if you don't receive services under the waiver, you will actually need to live in such an institution. The service coordinator uses a two-page form to evaluate the level of care.

- **Finances**
  - Social Security benefits are used to pay for care and treatment
    - Funds cannot be held back to pay for vacation, furniture etc. (Appendix F "SLRC NAFS Policy").
  - Consumer's receive a monthly personal allowance
    - Allowance may vary depending on unearned income (benefits such as SSI, SSA, RR, VA, etc.) and whether or not the person is employed.
    - Consumer is entitled to a minimum of $30.00 per month

- **Medical Care**
  - Consumer may need to locate new providers if medical providers were on campus vs. community
    - There may be a lack of providers accepting Medicaid or new Medicaid patients

- **Accessible and affordable housing**
  - Consumer pays for room & board with his/her benefits
    - There may be a wait list to apply for subsidized housing

- **Access to transportation**
  - Provider agency staff may or may not transport consumers in their own vehicles
    - Public transportation may be utilized (e.g. Call-A-Ride, Bi-State bus, etc.)

- **Living Options**
  - **Congregate Living (Group Home, Intermediate Care Facility (ICF), Residential Care Facility (RCF I or II), Skilled Nursing Facility (SNF)**
    Congregate settings are those that include multiple unrelated individuals who are provide care in a single dwelling. Eligibility may be specific to the facility, the individual's needs, the least restrictive environment identified by the support plan, or the person's choice. The individual's habilitative needs should be best met by residing in a congregate living setting and the setting must be able to provide the person's documented support needs.

  - **Family Living Arrangement (FLA)**
    A FLA is a single family or individual residence offering a living alternative to three or fewer persons in addition to the family. This situation provides an opportunity for the individual to become included into a family unit as opposed to living in larger group situations or having shift staff.

  - **Individualized Supported Living (ISL)**
    This is a non-facility based form of residential habilitation that provides support and training Services to an individual in the individual's own residence. Living in an ISL allows individuals even the most severe disabilities the opportunity for community living. Individuals may live alone or with their families or may share living arrangements with others. When living arrangements are shared, no more that three individuals with disabilities may reside together and qualify for ISL services.

Person Centered Planning

Personal Plans, which are individualized and person-centered, are prepared at the Habilitation Center during the Person-Centered Plan (PCP) meeting. The profile of the plan has written information such as the individual's vision for the future, personal interests likes and dislikes, preferred geographic location, religious preferences, family contact, needed personal supports, health status, and behavioral challenges. For those individuals residing in habilitation centers that would like to move to the community and their guardian and multidisciplinary team are in agreement, the habilitation center and regional center shall give them top priority, as they may fall under the Olmstead Act. ***(Appendix G - The Division of Mental Retardation and Developmental Disabilities' policy, "Referrals and Discharges to and from State Operated Habilitation Centers).***

When the team agrees that moving to the community is in the best interest of the consumer, the transition process begins. The transition process is documented on a checklist. The checklist is a guide for the team directing them through the process of transition. It is also a means to track referrals and barriers to those referrals. ***(Appendix H – "Transition Placement Process Checklist").***
The current person-centered plan is reviewed and rewritten to meet the Missouri Division of Mental Retardation and Developmental Disabilities' Person-Centered Planning Guidelines (Resource Section). Outcomes and action steps will be developed that will support the consumer's move to the community. Effective planning results in successful transitioning. A variety of assessment tools can be used to help everyone on the planning team to be aware of the transition areas and to think about how the information can be used to develop the transition plan.

Community Transition Leader or designee at the habilitation center completes and submits the **Consumer Residential Referral Form** to the Regional Center Transition Team Supervisor or

their designee ***(Appendix I - "Transitional Placement Referral")*** who in turn sends it to all regional centers and to potential appropriate residential provider agencies statewide. A "Community Placement Referral Packet" is sent to all residential providers who voice interest in supporting the consumer ***(Appendix J - "Placement Referral Packet ").*** From the list of agencies who offer to provide services, the consumer/guardian selects a residential provider. This will be the community agency which will provide and maintain the home and support staff for the consumer. A day provider may also be selected to provide vocational or other daytime opportunities. Individuals through the age of 21 are entitled and expected to participate in public education. Interested family members are encouraged to visit and meet potential providers to help the consumer decide on the appropriate providers before a decision is made. Regional Center and Habilitation Center staff will assist the consumer/guardian and family as needed in meeting and interviewing the potential providers.

Both the Habilitation Center and Regional Center staff work collaboratively with one another throughout the transition to make sure that all services and supports are provided for the consumer in the community. Staff will agree on who will assume the responsibilities of scheduling and facilitating the meetings. Ultimately, the Transition Coordinator is the person who is responsible to write and implement the person-centered plan for community placement.

There are three meetings which are important for the consumer, guardian and family members to attend. If they are unable to attend any of these meetings because of the time, location, or other reason, they should tell the Transition Coordinator or the person coordinating and facilitating these meetings. That person can help to make other arrangements. The information a guardian/family members can provide is valuable to the development of the Transition Plan.

Three Meetings for consumer, consumer's guardian and family members to attend:

- **The Planning Meeting**
- **The Transition Meeting**
- **The Closure Meeting**

At the **Planning meeting**, information is gathered about the consumer which will guide the development of the Transition Plan. The Transition Plan is the individualized plan to transfer an individual from the Habilitation Center to the community. It will include the supports and services needed in the community and identify who will provide these. It will also reflect the personal preferences and vision that the consumer has for his/her future. Assignments will be made to various individuals to complete tasks necessary to **begin** the process for a smooth, happy transition for the consumer.

The second meeting is called the **Transition meeting**. At this meeting the Transition Plan will be developed. The team will expand to include individuals who will be providing services and supports once the consumer moves to the community (e.g. Regional Center or SB 40 Board service coordinator; residential and day habilitation staff; school staff; employment staff; and individuals providing natural & community supports).

Assignments will be made to various individuals to complete tasks necessary to **accomplish** a smooth, happy transition for the consumer.

The last meeting is the **Closure meeting**. This meeting is to assure all activities/tasks pertaining to the transition have been **completed or a plan has been developed** to complete them. Any training needed by the community staff to learn about the consumer is scheduled if it hasn't already been completed. Any family member wishing to help train the new staff, by sharing their knowledge of their family member (consumer), is encouraged to actively participate in this training. A family's knowledge of their family member (consumer) can be invaluable to the staff.

When it is time for the consumer to move to his/her new home, the guardian/family members are invited to accompany them if he/she wishes. Later, the consumer's guardian/family members/ Habilitation Center staff and friends can plan to visit in the consumer's home and invite the consumer to visit them.

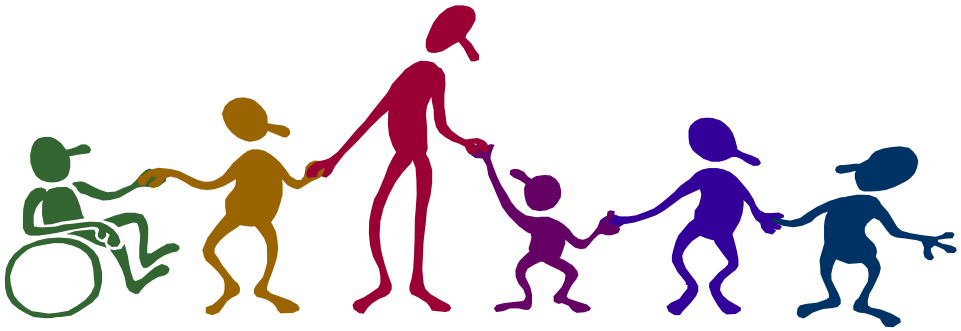
THE
TRANSITION PROCESS

"ROLES & RESPONSIBILITIES"

Following is a listing of roles and responsibilities for the Team during the Transition process. This list may help further explain the importance of every role in securing a new home and new life for our consumers.

TEAM MEMBERS

- CONSUMER
- GUARDIAN
- FAMILY MEMBERS
- CONSUMER'S FRIENDS
- HABILITATION CENTER STAFF
- ST. LOUIS REGIONAL CENTER STAFF
- RESIDENTIAL PROVIDER STAFF
- COMMUNITY AGENCY STAFF




GETTING READY

1. Consumer/Guardian/Family Members

Developing the Person-Centered Plan:

- Consumer/Guardian/Family Members participate in the development of the consumer's Person-Centered Plan (PCP). This plan is a work in progress that will be amended as the need arises.
  - Complete Transition Needs and Preference Survey
  - Attend meetings giving input about the consumer (personal profile)
  - Explore with the consumer what their needs and wants are

- Consumer/Guardian/Family Members participate actively in the development of consumer's PCP which includes amending the Profile & Action Plan as the transition process moves forward.

  - Brainstorm with team strategizing on the best means to achieve the outcomes desired
  - Assume responsibility in implementing assigned strategies listed in the Action Plan

Learning about the Transition Planning Process:

- Consumer's placement is reviewed at the annual Person Centered Planning meeting, as well as, quarterly.

- Reviews Olmstead Ruling and signs consent form to proceed with the community transition process.

- Meet with a Regional Center staff (Transition Coordinator) to learn about the transition planning process. Also ask questions about the Service Coordination Agencies which are available.

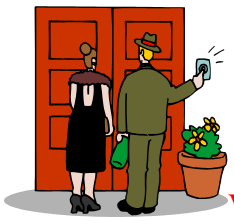
- Choose a Service Coordination Agency. St. Louis Regional Center & SB40 Boards are able to provide service coordination. The SB 40 Boards in the St. Louis area that provide service coordination are St. Louis City & Jefferson County. Neither SB 40 Boards in St. Charles County nor St. Louis County employs service coordinators at this time ***(Appendix K "SB 40 Boards Serving St. Louis Region").***

- Take sufficient time to check out potential Residential Support and Provider agencies. When decisions are made, sign consent forms for the Service Coordination Agency and other service providers as needed ***(Appendixes L – "Residential Support Providers" & M – "Day Programs").***

Selecting a Community Agency

- Meet with your Regional Center Transition Coordinator to get acquainted and consider community agencies. The Regional Center will have a list of interested community agencies who responded to your family member's Consumer Residential Referral Form.

- If you want to visit potential community agencies, ask your Transition Coordinator to arrange these visits with the community agencies you have selected.



Visit homes run by potential community agencies and ask lots of questions. You may want to utilize some type of evaluation tool when visiting community agencies that will assist you in choosing the agency(s) that are most appropriate for your family member ***(Appendix N – "Community Transition Visit Review").***

- After weighing all the things that are important to your family, select the community agency which you want to serve your family member. If the agency only provides residential services you may need to also select an agency to provide employment or other day services to your family member. Sometimes this decision can be better made once you begin the transition planning process.

2. Habilitation Center – BHC & SLDDTC

- Unit Program Supervisor
- Habilitation Specialist/Habilitation Center Service Coordinator
- Direct Care I, II, III
- Medical Staff
- Social Worker

Learning about the Transition Planning Process

Staff supporting consumers who are targeted to transition from Habilitation Center to Community Living (ISL, Group Home, Nursing Home, Family Living Arrangement) will attend the in-service "Let's Get Moving" to learn the Community Transition Process.

Preparation for the Transition (Getting Ready):

- Consumer's placement is reviewed at the annual Person Centered Planning meeting, as well as, quarterly.
- Consults with Transition Coordinator if necessary to assess appropriate residential options
- Olmstead Ruling is explained to consumer/guardian
- Consent is obtained from consumer/guardian to proceed with community transition process
- Consumer is identified, along with his/her team, to move into the community by placing their name on the community transition list
- Completes Consumer Residential Referral Form

- Submits Consumer Residential Referral Form & Placement Packet to the Placement Coordinator that initiates the transition process with the Regional Center

Medical Staff

- Assures that all assessments are current and that all recommendations have been addressed. These areas may include:
  - Physician's Medical Report
  - Medical specialty consults (e.g., neurological, orthopedic, cardiology, psychiatric, psychological)
  - Immunization reports
  - Pharmacy Reports/Doctor's Orders
  - Additional Medical Information
- Assess the medical strengths and weaknesses of the individual (Nursing Care Plan)
- Complete Medical History including medication history (Annual Nursing Report)
- Forward assessment information to the Habilitation Center Transition Leader

Transition Leader/ Unit Program Supervisor/Social Worker

- Notifies SLRC Service Coordinator that consumer has been placed on the community transition list.
  - Referral for Residential Support is completed with the assistance of the Transition Coordinator
  - Submits all documentation as required to the Transition Coordinator
- Assures that all assessments are current and that all recommendations have been addressed. These areas may include:
  - Community Transition Assessment Tools
- Forwards person-centered plan and any other pertinent information to the Transition Coordinator

3. Regional Center

- Community Placement Coordinator
- Transition Coordinator
- Service Coordinator or (SB 40 Board Service Coordinator)
- Service Coordinator Supervisor
- Quality Assurance
- Utilization Review Committee
- Business Office Reimbursement Officer
- Assistant Director/Director

Learning about the Transition Planning Process

Staff supporting consumers who reside in Community Living (ISL, Group Home, Nursing Home, and Family Living Arrangement) will attend the in-service "Let's Get Moving" to learn the Community Transition Process.

Preparation for the Transition (Getting Ready):

- Consumer is identified, along with his/her team, to move into the community by placing their name on the community transition list. MEDICAID WAIVER ELIGIBILITY IS DETERMINED (ACTIVE MEDICAID & WAIVER DIAGNOSIS)

Transition Coordinator

- May act as a consultant at the consumer's annual Person Centered Planning meeting, where the multidisciplinary team shall assess appropriate residential options. At the time of the assessment, all residential options will be reviewed with the consumer and his/her guardian.
- Reviews the "Referral for Community Placement", completed by Habilitation Center staff, and submit it to the Community Placement Coordinator to initiate the transition process.
- Obtains and reviews current Person Centered Plan and other pertinent documentation to prepare for the transition process

4. Residential Provider

- Residential Director
- Residential Supervisor
- Direct Care Staff

Learning about the Transition Planning Process

Residential agency staff will attend the in-service "Let's Get Moving" to learn the Community Transition Process.


PLANNING MEETING

1. Consumer/Guardian/Family Members

- Participate in the planning meeting with your Transition Coordinator, Habilitation Center Unit Program Supervisor, Habilitation Center Service Coordinator, Social Worker, the community agency(s) and direct care staff members who knows your family member best. You are encouraged to invite friends, relatives, and others in your loved one's circle of support, to participate in this planning meeting and subsequent meetings. The consumer's support team members are asked to submit information that is relevant to the development of the person-centered plan if they are unable to attend any of these meetings. All team members either in attendance or who have submitted documentation for the meeting will be noted on the meeting signature page of the plan ***(Appendixes O - Planning, Transition & Closure Meeting Attendance").***

- Together, discuss and decide on your expectations, preferences, non-negotiables, timelines, projected move date, community resources which are needed, staffing needs, and any special concerns. At this meeting you will also agree upon a date, time, and place for the Transition Meeting.

- Begin getting acquainted with your family member's Transition Coordinator. The Transition Coordinator will help you make sure your family member is getting the support and services they need in the community. The Transition Coordinator works for your family member and is there to always represent his/her best interest.

- Approximately two weeks after this meeting, the Transition Person-Centered Plan will be sent to you. You should review it carefully and advise your Transition Coordinator of any concerns you have.

2. Habilitation Center

Medical Staff

- Analyze the medical resources the individual may require in the community
- Assist in the determination of the appropriateness of the community setting chosen
- Attend planning meeting for all individuals. In exceptional circumstances when it is known in advance that attendance is not possible, a written report must be submitted to the Interdisciplinary Team Leader prior to the date of the meeting, summarizing the following:
  - Medical strengths and weaknesses of the individual
  - Ability to cope with major life changes
  - The medical resources the individual may require in the community
  - Any specific medical issues which should be addressed in the transition plan.

Unit Program Supervisor, Social Worker, Habilitation Center Service Coordinator, Direct Care Staff

- Participates in the planning meeting for all individuals. In exceptional circumstances when it is known in advance that attendance is not possible, input by appropriate staff to the Person-Centered Plan must be submitted to the Interdisciplinary Team Leader prior to the meeting.
- Provides input to amend current Person-Centered Plan expanding on the consumer's profile following the standards listed in the Medicaid Waiver "Person-Centered Planning Guidelines" & "Missouri Quality Outcomes Guide".
- Provides input to the action plan that will reflect what is stated in the consumer's profile that will ultimately achieve the outcome that the consumer will live in the community.
- Assures that all assessments are current and that all recommendations have been addressed.
- Completes Inventory Checklist noting items that must be purchased prior to the move. (Appendix P).
- Completes Log of Contacts (Appendix Q)
- Forwards assessment information to the Transition Coordinator

3. Regional Center

Regional Center Transition Coordinator

- Introduces self to consumer/guardian/family
- Schedules and invites team members to the Planning Meeting
- Obtains appropriate authorization, "Authorization for Disclosure of Medical/Health Information"
- Facilitates Planning Meeting
- Draft of Transition Plan is developed by rewriting current Person Centered Plan, utilizing information on current reports in the medical record as well as new information obtained from assessments and surveys.
- Ensure that the plan describes all of the consumer's support needs that WILL JUSTIFY COSTS ON A RESIDENTIAL BUDGET ***(Appendix R – "St. Louis Regional Center Guide for funding Individualized Supported Living Arrangements")***
- Completes the Placement Referral Packet gathering information/documentation on the Medicaid Waiver Referral Packet checklist (Appendix R).
- Submits Consumer Residential Referral Packet to Community Placement Coordinator which includes updated PCP, Health Care Inventory, medical, nursing, psychological, social history, PT, OT & ST reports and Behavior Support Plan.
- Q. A supervisor receives a copy of the referral packet for review
- Introduces consumer/guardian to interested providers
- Maps out community of interest with consumer/guardian
- Explores work or day program options with consumer/guardian (supported employment, sheltered workshop, day habilitation, adult day care etc.)
- Facilitates referrals to identified providers for work or day programs
- Implements assigned strategies on Action Plan regarding transition, noting completion of strategies on plan

- Maintains a working file folder on all consumers assigned following HIPAA guidelines.
- Forwards Transition Plan Draft and all interview/assessment/survey tools/evaluations to supervisor for review
- Forwards Health Inventory, current nursing care plan, etc. to Quality Assurance Supervisor in preparation for the Transition meeting. The Q.A. Supervisor will assign a Q.A. nurse to review documents.
- Keeps log of all contacts ***(Appendix S – "Log of Contacts")***

Community Placement Coordinator

- Sends referral to Residential Providers
  - Transition Placement Referral
- Sends Consumer Residential Referral Packet to interested providers
- Ensures that consumer becomes active client on a administrative case load by sending the face sheet to Medical Records for admission to SLRC service system
- Maintains a working file folder on all consumers assigned following HIPAA guidelines
- Ensures Waiver Slot is obtained

Quality Assurance

- QA supervisor reviews Consumer Residential Referral Packet
- QA supervisor and/or QA representative will be available to provide consultation to the Transition Coordinators regarding transition planning

Quality Assurance Nurse

- Reviews information provided by Transition Coordinator in order to be prepared for the transition meeting. The Q.A. nurse determines whether a visit to meet the person is necessary before the transition meeting, based on the information provided by the Transition Coordinator. The health and safety needs of the consumer will determine if Q.A. nurse attendance is required at the transition meeting.

AFTER THE PLANNING MEETING

4. Residential Provider

- Receives Placement Referral Profile from Regional Center Placement Coordinator
- Expresses interest in providing services
- Receives Placement Referral Packet from Regional Center Placement Coordinator
- Send Regional Center Placement Coordinator budgetary comments


TRANSITION MEETING

1. Consumer/Guardian/Family Members

- Once a provider is chosen, the Transition Meeting is scheduled.

- Participate in the Transition Meeting where you will meet your Regional Center or SB 40 Board Service Coordinator and representatives from the agencies that will provide community services and supports.

- The Transition Coordinator brings a draft of your family member's Transition Person-Centered Plan to this meeting that reflects transition from habilitation center living to community living. At this meeting everybody agrees on the critical issues which still need to be addressed, the actions that the plan calls for, and remaining timelines.

- Within 10 days after the Transition Meeting, review the final transition plan and sign it if you agree that the plan meets the needs of your family member.

- Work with the Transition Coordinator to schedule visits with potential residential providers and community agencies to get acquainted with potential roommates and the communities in which they reside. The number of visits you schedule will vary. The important thing to remember is not to rush the transition process but to rather take your time deciding what provider, roommate, and community are best for your family member.

2. Habilitation Center

Medical Staff

- A representative attends the transition meeting for all individuals.
- Continue to give professional input regarding the medical resources the individual may require in the community and the appropriateness of the community setting that is needed.

.PRE-DISCHARGE SUMMARIES BROUGHT TO THE TRANSITION MEETING

Unit Program Supervisor, Social Worker, Habilitation Center Service Coordinator, Direct Care Staff

- Team participates actively in Transition Meetings
- Ensures that Consumer/Guardian Approve of the Move
- Provides updates to the current person-centered plan for the expanding on the profile and action plan that includes developing transition outcomes
- Reviews and signs the Transition Plan assuring appropriateness of community resources, services, and residential setting

- Implements strategies that they are responsible for on Transition Plan tracking completion dates
- Gathers Financial Information for Transition Coordinator
- Assists with scheduling visits with potential roommates and the communities in which they reside
- Updates log of all contacts
- Provides necessary supports for visits to occur
- Provides assistance to Consumer/Guardian/Family completing "Post Visit Review"
- Completes "Visit Review Checklist" with consumer if there is no involvement from guardian/family
- Obtains appropriate authorizations on "Authorization for Disclosure of Medical/Health Information" forms
- Coordinates Furnishings (e.g. bed, dresser, nightstand, etc.) updating Inventory Checklist

3. Regional Center

Regional Center Transition Coordinator

- Notifies Transition Supervisor to arrange for Community Service Coordinator to be assigned and invited to attend transition meeting
- Schedules Transition Team Meeting (Team has expanded to include Provider Staff)
- Notifies QA Nurse assigned to the residential provider agency (which has accepted the referral) of the date and time of the Transition meeting
- Notifies Regional Center or SB 40 Board Service Coordinator of date and time of Transition meeting
- Facilitates the Transition Meeting with Habilitation Center staff
- Discuss move out transportation options (Family, Staff, Moving Van)
- Ensures that all assessments are current and that all recommendations have been addressed. These areas may include:
- Reviews the Transition Plan ***draft*** with the team obtaining input from all members of the team
- Writes Transition Plan following the guidelines of Utilization Review
- Works with Habilitation Center and Residential Providers to schedule visits with…
  - Potential Roommates
  - Potential Providers
  - Community Recreational Sites
  - Potential Day Activity Sites (employment, recreational, adult day care)
- Ensures appropriate authorizations on "Authorization for Disclosure of Medical/Health Information" forms
- Completes Medicaid Waiver Packet ***(Appendix T) - "Medicaid Waiver Referral Packet Checklist")REVERIFY ACTIVE MEDICAID AND WAIVER DIAGNOSIS***
- Reviews ISL Budget submitted by Residential Provider
- Disseminates Transition Plan to all team members and obtains signatures on consent page
- Submits the Transition Plan to the UR Committee for approval after completing the checklist (includes ISL Budget/SERVICE AUTHORIZATION FORM)

- Sends a copy of the Transition Plan to all team members once approved by UR Committee

Regional Center Service Coordinator/SB 40 Board Service Coordinator

- Provides information regarding resources, programs, etc. upon request of Transition Coordinator
- Attends Transition Meeting
- Works with Transition Coordinator as needed to ensure that the Transition Plan meets Utilization Review Committee criteria.

Quality Assurance Nurse

- Receives notification from Transition Coordinator regarding what agency will provide residential support, and the date/time/place of the transition meeting
- Participates in Transition Meeting (in person or per nursing report) for those consumers receiving services from the residential provider they are assigned to ***(Appendix U – "SLRC Quality Enhancement Nursing Assignments").***
- Addresses health and safety needs and issues assuring they are reflected in the Person-Centered Plan.

Quality Assurance

- QA representative will be available to provide consultation and/or technical assistance to the Transition Coordinators with the development of an ISL budget, if applicable, once the person-centered plan has been completed

4. CHOSEN Residential Provider

- Attends Transition Meeting
- Questions and concerns expressed are addressed by current team members
- Develops cost of new placement and submits ISL Budget
- Implements assigned strategies on Action Plan regarding transition.
- Works with Habilitation Center and Transition Coordinator to schedule visits with Potential Roommates (MUST OBTAIN PRE-APPROVAL FOR TRANSITION FUNDS AND START-UP FUNDS FROM REGIONAL CENTER DIRECTOR)
  - Potential Community Providers
  - Community Recreational Sites
  - Potential Day Activity Sites (employment, recreational, adult day care)
- Provides feedback to the team following visits
- Acknowledges if they are unable to meet the needs of the consumer, therefore will withdraw their name from the potential provider list


CLOSURE MEETING

1. Consumer/Guardian/Family Members

- Participate in the closure meeting where all assigned tasks/activities are reviewed to ensure they are either completed or there exists a clear plan for them to be completed and final preparations are made for the move.

2. Habilitation Center

Medical Staff

- Report that the following activities have been completed:

  - Arrange for a **30-DAY** supply of medication to accompany the person on the day of the move and ensure a prescription is written for all medications.
  - Send Medical information to the Community Primary Care Physician before the move.
  - Complete telephone contact with the Community Primary Care Physician before the move if necessary.
  - Complete Discharge summary and send to Community Care Physician before the move.
  - Perform Exit Medical Exam – Physician/Nurse Practitioner
  - Ensure Physician orders accompany the consumer on moving day
  - Complete other activities as specifically identified in the Transition Plan.

Unit Program Supervisor, Social Worker, Habilitation Center Service Coordinator, Direct Care Staff

- Participate in the closure meeting where all assigned tasks/activities are reviewed to ensure they are either completed or there exists a clear plan for them to be completed and final preparations are made for the move.
- Discharge summaries prepared and brought to closure meeting

3. Regional Center

Regional Center Transition Coordinator

- Facilitates the closure meeting where all assigned tasks/activities are reviewed to ensure they are either completed or there exists a clear plan for them to be completed and final preparations are made for the move.
- Ensures that the Community Placement Coordinator has a copy of the Transition Plan and approved budget/SERVICE AUTHORIZATION FORM

4. Residential Provider

- Participates in the closure meeting where all assigned tasks/activities are reviewed to ensure they are either completed or there exists a clear plan for them to be completed and final preparations are made for the move.

PREPARING FOR THE MOVE

1. Consumer/Guardian/Family Members

- Participate in training for community staff given by Habilitation Center staff if you want. Share information with community staff that will be caring for your family member.

- Help your family member and community staff shop for furnishings and decorations for their new home.

2. Habilitation Center

Medical Staff

- Ensure that all of the consumer's medications and/or prescriptions are given to residential provider with necessary instructions.
- Assigned staff will conduct follow up visits for up to six months to ensure consumer is acclimating to his/her new environment and is coping with major life changes that are occurring.
- Continue to share information with the new community staff about the consumer and be available to answer questions as staff get to know him/her better

Unit Program Supervisor, Social Worker, Habilitation Center Service Coordinator, Direct Care Staff

- Completes Discharge Inventory Checklist ***(Appendix Q- Discharge Inventory Checklist")***
- Coordinates moving of furniture and personal items
- Continue to share information with the new community staff about the consumer and be available to answer questions as staff get to know him/her better
- Schedule visits to consumer's home
- Schedule visits for consumer to come back and visit staff and residents at Habilitation Center

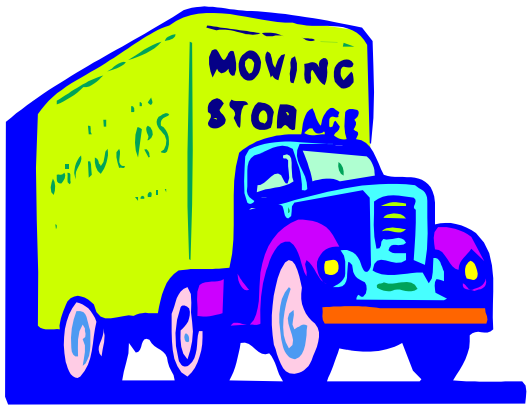
3. Regional Center

- Continue to monitor the implementation of the plan to ensure a safe smooth transition.

4. Residential Provider

- Participates in training from Habilitation Center staff and other team members as needed.
- Request information from Habilitation Center staff, Transition Coordinator and family as needed.
- Assist consumer, guardian, family members & Transition Coordinator to shop for furnishings and decorations for consumer's new home.

DURING THE MOVE



1. Consumer/Guardian/Family Members

- Accompany your family member on the move if you are able.

- Continue to share information with the new community staff about your family member and be available to answer questions as staff get to know him/her better.

2. Habilitation Center

Medical Staff

- Ensure that all of the consumer's medications and/or prescriptions are given to residential provider with necessary instructions.
- Assigned staff will conduct follow up visits for up to six months to ensure consumer is acclimating to his/her new environment and is coping with major life changes that are occurring.
- Continue to share information with the new community staff about the consumer and be available to answer questions as staff get to know him/her better

Unit Program Supervisor, Social Worker, Habilitation Center Service Coordinator, Direct Care Staff

- Completes Discharge Inventory Checklist ***(Appendix Q- Discharge Inventory Checklist")***
- Coordinates moving of furniture and personal items
- Continue to share information with the new community staff about the consumer and be available to answer questions as staff get to know him/her better
- Schedule visits to consumer's home
- Schedule visits for consumer to come back and visit staff and residents at Habilitation Center
- Accompany consumer to their new home

3. Regional Center

During and after the Move

Regional Center Transition Coordinator

- Accompany consumer on the move if you are able
- Notifies SLRC Business Office Reimbursement Officer that consumer has moved into community placement, therefore a change of payee is needed.
- Provides Primary Service Coordination for 30 – 60 days after the move (includes Medicaid Waiver monitoring).
- Visits with consumer at least weekly for the first 30 days to ensure he/she is acclimating to his/her new home and community
- Continue to share information with the new community staff about the consumer and DMH Placement Coordinator and be available to answer questions as staff get to know him/her better.
- Work with Residential Provider staff & team to schedule the initial community Person-Centered Plan meeting
- Work with Residential Provider to schedule visits with friends and staff from Habilitation Center

Community Placement Coordinator

- Sends all required forms to the SLRC Business Office Reimbursement Officer
  - Notice of Placement
  - Payeeship Information
  - ISL Budget (if applicable)
- Inputs information in the Community Placement Tracking system

Regional Center Service Coordinator/SB 40 Board Service Coordinator

- Meet with the Transition Coordinator as needed throughout the 30 – 60 day time period to ensure smooth transition changing primary service coordination from the Transition Coordinator to Service Coordinator on Placement Team.
- Primary service coordination responsibilities will transfer from the Transition Coordinator to the Service Coordinator (SLRC or SB40 Board) within the 30 – 60 day time period as agreed upon between the Placement Team Service Coordinator Supervisor, Service Coordinator and the Transition Coordinator (Team will have input as to the appropriate time of transfer).

SLRC/SB 40 Board Placement Supervisors

- Supervises Transition Coordinators through the Transition Process
- Monitors Progress of Each Client Move
- Assigns Service Coordinator
- Monitors Waiver Packets

- Ensures services are correctly authorized
- Trouble Shoots Along the Way
- Attends Regular Problem-Solving Meetings
- Supports SLRC/SB 40 Board Service Coordinator with UR Process
- Ensures entry of budget/SERVICE AUTHORIZATION FORM
- Do not typically attend Transition meetings

Utilization Review Committee: QA Representative, Placement team Supervisor, Placement team Service Coordinator III, II, I

- Reviews Person-Centered plan, nursing review if applicable & budget
- Reviews Person-Centered Plan 45 days after date of move (New budget is effective on day 60)
- Do not typically attend Transition meetings

4. Residential Provider

- Accompany the consumer on the move if you are able
- Reviews "Discharge Inventory Checklist" and signs form to confirm receipt of the items checked on the list.
- Continue to share information with the team about the consumer and be available to answer questions from any team member

AFTER THE MOVE

Consumer/Guardian/Family Members

- Visit your family member.
- Continue to share information with the new community staff about your family member and be available to answer questions as staff get to know him/her better.
- Work with your Service Coordinator to schedule the initial community Person-Centered Plan meeting.
- Actively participate in your family member's initial Community Placement Person-Centered Plan meeting approximately 30 days after the move. The new plan will be implemented within 60 days after the move.

4. Habilitation Center

Unit Program Supervisor, Social Worker, Habilitation Center Service Coordinator, Direct Care Staff

- Six months of intense follow-up: Staff at the habilitation center who previously worked with the consumer and who are familiar with the person's specialized care needs will be available to confer with provider staff and to make recommendations on treatment methods. This includes participation in the 30 day review.

3. Regional Center

Business Office Reimbursement Officer

- Receives information from Transition Coordinator to complete an application to have SLRC become payee for Social Security benefits
- Receives documentation from Community Placement Coordinator
  - Notice of Placement
  - Payeeship Information
  - ISL Budget (if applicable)
- Sets up community placement contract (DMH 57)
- Sets up NAFS account

Utilization Review Committee: QA Representative, Placement team Supervisor, Placement team Service Coordinator III, II, I

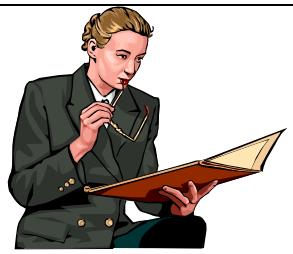
- Appropriate MRDD staff will, for six months, visit the resident with increased frequency than is done on a routine basis to ensure safety and correction of any problems with the provider's delivery of appropriate services.
- Visits will assess the overall health, welfare and care regimen to ensure the person's condition has not regressed since leaving the habilitation center.
- After six months, the interdisciplinary team will determine if routine quality assurance procedures are sufficient.

4. Residential Provider

- Continue to share information with the team about the consumer and be available to answer questions from any team member
- Locates work or day program if not yet found
- Work with Regional Center Placement Service Coordinator to schedule the initial community Person-Centered Plan meeting
- Completes Community Person-Centered Plan
- Submits plan to Service Coordinator for Utilization Review (within 45 days after placement)
- Schedules visits with friends and staff from the Habilitation Center providing support as needed (keeping connected to the past to ensure stability in the present and future).

Timelines

Before, during and after the move, it is very important for timelines to be adhered to by all parties involved for transition to be successful.

 **Before and after the move**	▪ The Utilization Review Committee reviews initial community person-centered plan that will approve the budget for services from day 1 to day 60 of the plan year. ▪ The Utilization Review Committee reviews community person-centered plan that will approve the budget for services from day 60 through the plan year.
 **Day 1 – 60 days**	• DMH Transition Coordinator is the primary service coordinator for 30 – 60 days • RC/SB 40 Board Service Coordinator is the secondary service coordinator for 30 – 60 days and assumes the primary role on the day that the team decides. • Both service coordinators will partner with consumer, guardian, family and community providers to develop the PCP • During the initial 30 days, the team continues to communicate with one another evaluating current plan and making recommendations. • Residential Habilitation provider schedules community placement person-centered plan meeting during the last week of the 30 day period. • Transition Coordinator and/or the Service Coordinator ensure that the placement review meeting has been scheduled by the fourth week of the initial month of placement. • Transition Coordinator and/or Service Coordinator ensure that the community person-centered plan has been submitted by the residential provider by day 45 • Frequent visits by MRDD staff to ensure safety and correction of any problems with the provider's delivery of appropriate services.
Day 31 – Day 45	• Residential Provider ensures that all information is gathered and writes the community person-centered plan • Residential Provider submits the initial community person-centered plan by day 45 to Transition Coordinator for review • Transition Coordinator reviews plan and submits plan to the Utilization Review Committee for approval
Day 61 -	▪ With approval from the transition team, the consumer will transition to the routine policy for on-going quality assurance

The Appeal Process

Within the Division of MR/DD, there exist appeal processes for a variety of reasons, ranging from a determination of ineligibility to a reduction of services.

For All Individuals

- Through the Leake Consent Decree has an appeal process for when an individual is determined to be not eligible for any services from MR/DD, which is outlined in the Code of State Regulations, 9 CSR 45-2.020.
- The Leake Consent Decree, through the CSR has an appeal process for when an individual is determined not eligible to receive a specific GR funded MR/DD service by Statute.
- The Leake Consent Decree, through the CSR has an appeal process for when a person is determined not eligible for the MR/DD Waiver or Lopez Waiver by Policy. In this situation, the individual also has the Statutory Right to appeal to the Division of Medical Services (DMS).
- The right to appeal to the Department of Social Services (DSS) if determined not eligible for Medicaid by the Division of Family Services (DFS).
- The right to appeal to (DSS/DFS) if any Medicaid State Plan service is either denied, terminated or reduced.

For Individuals in Either the MR/DD Waiver or the Lopez Waiver

- When the person is determined the individual is no longer eligible for either waiver and terminates the person from the waiver, the individual has the right to appeal to DMH using the CSR, and DSS/DMS.
- When a service requested by an individual is denied, there is a right to appeal to DMH using the CSR and DSS/DMS.
- When the level or amount of a waiver service is reduced, there is a right to appeal to DMH using the CSR and DSS/DMS.
- When the service is terminated, there is a right to appeal to DMH using the CSR and DSS/DMS.
- There are guidelines regarding accessibility to waiver services as well as sufficiency of amount, duration and scope of services**

Appeals for MR/DD and Lopez Waiver

The Waiver manual outlines the appeals process which to follow.

- As you will note in the waiver manual, "while NOT required to do so, MR/DD waiver participants are encouraged to begin with the DMH appeal process." The manual goes on to indicate that people may appeal to DMS at any time during the appeal process with MR/DD. The service coordinator will assist with this appeal to DMS.

- To appeal to DMS, the request for an appeal MUST be initiated within 90 days of the date of action. To request an appeal through the Medicaid agency, the person may write to the Division of Medical Services, Recipient Services Unit, P.O. Box 6500, Jefferson City, MO 65102-6500, or call at (800) 392-2161.

Appeals through the Code of State Regulations as mandated by the Leake Consent Decree

- The DMH Leake Process does not specifically mention Medicaid Waiver services; however the process for DMH appeals under the waiver is identical for any adverse action, not just for eligibility issues.

- The appeals process is outlined in 9 CSR 45-2.020, and in a brochure entitled *Your Right to Appeal…*, published by DMH's Office of Public Affairs. The new Case Management Guide will also have a section regarding Appeal rights.

- If the appeal is service related, please note that the service will not stop during the appeal, and if the individual is in a waiver program, they must be given at least 10 days written notice before the action is taken.

Summary of Rights

During the Transition Planning Process

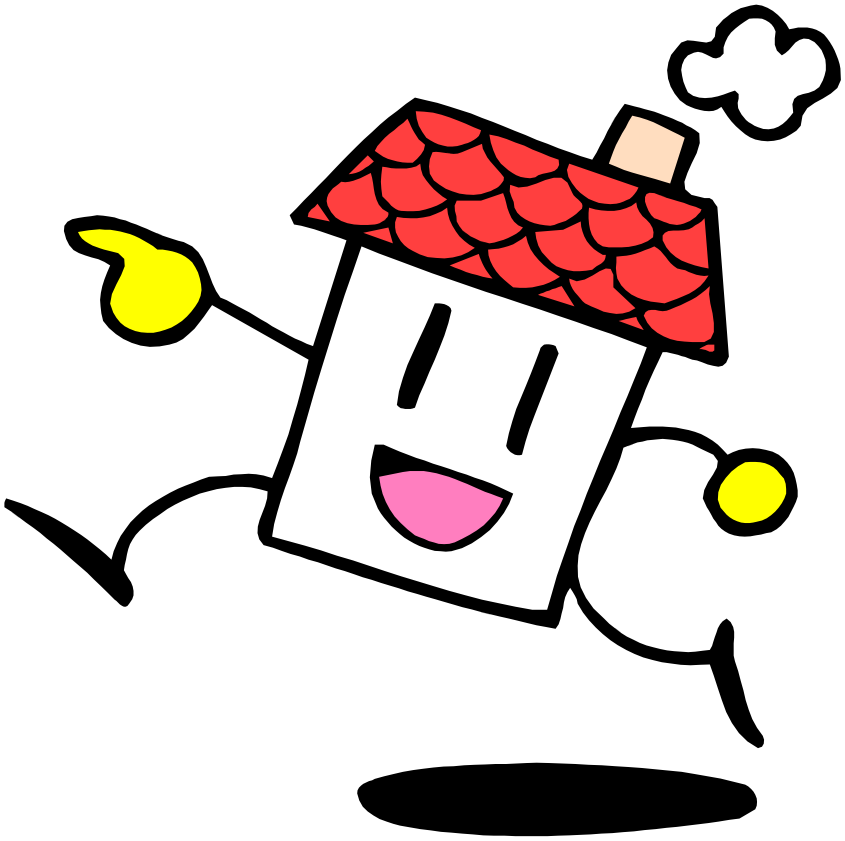
The transitioning individual has the following rights:

- K to be actively involved in the development of your Transition Plan
- K to state your wishes, expectations, and needs so that they are included in your Plan
- K to have help from a person who knows you best and can understand what you are trying to communicate
- K to attend transition meetings
- K to sign the Transition Plan if you agree with it
- K to select the area where you want to live
- K to decide who you want to live with, if anybody
- K to select your Service Coordinator Agency and community providers
- K to pick out the furniture and decorations for your new house

The family or guardian has the following rights:

- K to be actively involved in the development of the Transition Plan
- K to state your wishes and expectations so that they are included in the Transition Plan
- K to have special accommodations to attend meetings if you need them such as transportation or changing the time or location of the meeting
- K to attend transition meetings
- K to sign the Plan if you agree with it
- K to help your family member select a Service Coordinator, advocate (if one is needed), and community providers
- K to help your family member select the area in which to live
- K to help your family member select furnishings and decorations for the new home
- K to accompany your family member on the day of the move if desired by the family member
- K to attend training for new community staff and share information with them if it is okay with your family member
- K to visit your family member in their new home if desired by your family member.

APPENDIX



Tools for Planning "Community Transition"

Appendix A

DMH Letterhead

Name (Guardian)
Address
Address

RE: Consumer Name

Dear

As we previously discussed, _____Interdisciplinary Team is recommending that we refer _____ to the St. Louis Regional Center to explore community placement options. Concurrent with exploring placements, we will also be evaluating _____for other lifestyle options such as training or vocational placement.

Enclosed you will find a three page "**Needs and Preference Survey"** which not only offers brief explanations of the options that are available, but will also allow you to provide input as to what you desire for _____.

By signing and returning this letter, you are giving consent to proceed with the Community Placement Options referral process. The information you provide on the "Needs and Preference Survey" will ensure that the transition process promotes opportunities, choices and community membership.

Sincerely,

_____
Name, Title

I am authorizing _____ Habilitation Center to initiate the "Community Placement Options" referral process. I have also enclosed the "Needs and Preference Survey".

_____ _____
Guardian's Signature Date

The Department of Mental Health does not deny employment or services because of race, sex, creed, marital status, religion, national origin, disability or age of applicants or employees.

Appendix B

Consumer Transition Needs and Preference Survey

This survey is designed to help determine what type of experiences and education the consumer will need to prepare for life after Habilitation Center living. It will be used to develop short-term and long-term outcomes which will be discussed at the consumer's Transition meetings.

Consumer's Name: _____

Parent/Guardian's Name: _____

1. **What kind of work or education do you hope to see your family member participating in after his/her move? Full-time / part-time**

__ __ Vocational Training
__ __ Competitive Employment
__ __ Supported Employment
__ __ Sheltered Employment
__ __ Volunteer Experience

2. **Is there a particular kind of work or education that your family member is currently interested in? If so, please specify:**

_____
_____
_____
_____

3. **Where do you hope that your family member will ultimately live?**

__ **Congregate Living (Group Home, Intermediate Care Facility (ICF), Residential Care Facility (RCF I or II), Skilled Nursing Facility (SNF)**
Congregate settings are those that include multiple unrelated individuals who are provide care in a single dwelling. Eligibility may be specific to the facility, the individual's needs, the least restrictive environment identified by the support plan, or the person's choice. The individual's habilitative needs should be best met by residing in a congregate living setting and the setting must be able to provide the person's documented support needs.

__ **Family Living Arrangement (FLA)**
A FLA is a single family or individual residence offering a living alternative to three or fewer persons in addition to the family. This situation provides an opportunity for the individual to become included into a family unit as opposed to living in larger group situations or having shift staff.

__ **Individualized Supported Living (ISL)**
This is a non-facility based form of residential habilitation that provides support and training Services to an individual in the individual's own residence. Living in an ISL allows individuals Even the most severe disabilities the opportunity for community living. Individuals may live alone or with their families or may share living arrangements with others. When living arrangements are shared, no more that three individuals with disabilities may reside together and qualify for ISL services.

4. Is there a particular neighborhood, city or locality you hope your family member will live in? If so, please specify:

_____
_____
_____

5. Is there a particular provider that you are already interested in?

_____
_____

6. What type of community participation do you hope will be available to your family member? (Check all that apply)

__ Memberships in civic clubs or organizations

__ Community recreational activities and membership

__ Religious and cultural activities of affiliation

__ Use of transportation. Specify if possible _____

__ Continuing education

__ Other _____

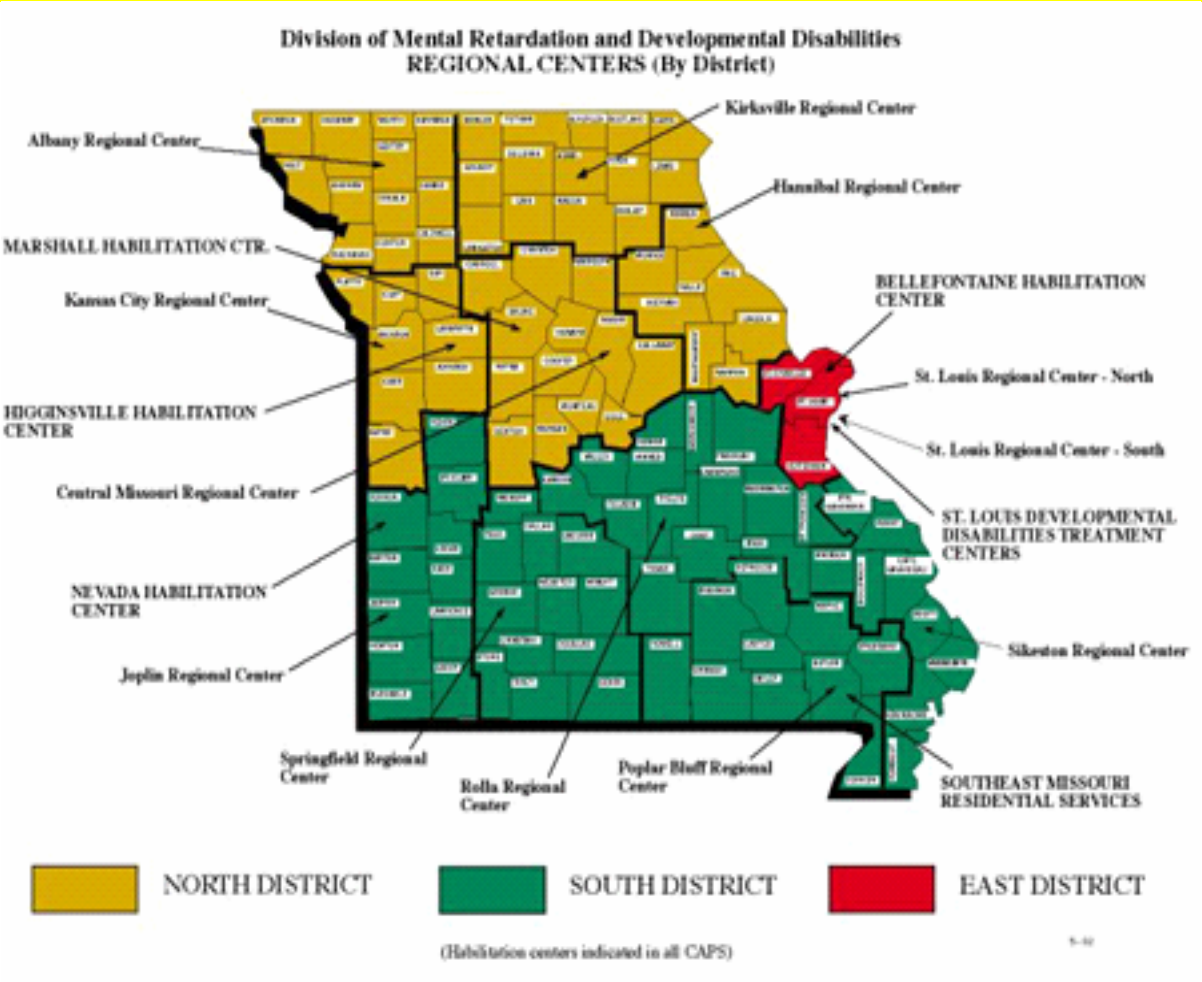
7. What training programs do you feel would be helpful to your family member now and after his/her move? (Check all that apply)

__ Classroom skills training
__ Community Work Experience
__ Supported Employment
__ Vocational Training
__ Self-Care/Safety Class
__ Class on Housekeeping
__ Class on Money & Budgeting
__ Class on Clothing Care
__ Handling Emergencies
__ Cooking and Nutrition Class
__ Home Repairs/Maintenance
__ First Aid and Health Class
__ Shopping
__ Emotional Awareness
__ Physical Fitness
__ Self Advocacy/Assertiveness
__ Use of Public Transportation
__ Political Awareness
__ Community Awareness
__ Evaluation (Specify Type Needed)
__ Referral (Specify to Whom)
__ Other _____

Date: _____

Appendix C

MRDD Facility Map (Thumbnail)



Appendix D

MISSOURI DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES
FACILITY LISTING

ALBANY REGIONAL CENTER
809 North 13th Street
Albany, MO 64402
660-726-5246; TDD 660-726-5844; FAX 660-726-5165
Jerry Carpenter, Director

BELLEFONTAINE HABILITATION CENTER
10695 Bellefontaine Road
St. Louis, MO 63137
314-340-6000; TDD 314-340-6290; FAX 314-340-6199
Janet Simons, Acting Superintendent

CENTRAL MISSOURI REGIONAL CENTER
1500 Vandiver Drive, Suite 100
Columbia, MO 65202
573-882-9835; TDD 573-882-9835; FAX 573-884-4294
Sandy Wise, Director

HANNIBAL REGIONAL CENTER
805 Clinic Road, P.O. Box 1108
Hannibal, MO 63401
573-248-2400; TDD 573-248-2415; FAX 573-248-2408
Linda Bowers, Director

HIGGINSVILLE HABILITATION CENTER
Morris Drive, P.O. Box 517
Higginsville, MO 64037
660-584-2142; TDD 660-584-3935; FAX 660-584-6244
Wayne Crawford, Acting Superintendent

JOPLIN REGIONAL CENTER
3600 East Newman Road, P.O. Box 1209
Joplin, MO 64802-1209
417-629-3020; TDD 417-629-3020; FAX 417-629-3026
Diana Garber, Director

KANSAS CITY REGIONAL CENTER
821 East Admiral Boulevard
P.O. Box 412557
Kansas City, MO 64106 street address) 64141 (PO Box)
816-889-3400; TDD 816-889-3326; FAX 816-889-3325
Jerry Carpenter, Director

KIRKSVILLE REGIONAL CENTER
1702 East LaHarpe
Kirksville, MO 63501
660-785-2500; TDD 660-785-2500; FAX 660-785-2520
Linda Bowers, Director

MARSHALL HABILITATION CENTER
Slater Street, P.O. Box 190
Marshall, MO 65340
660-886-2201; TDD 660-886-6929; FAX 660-831-3071
Mary Fangmann, Superintendent

NEVADA HABILITATION CENTER
2323 North Ash
Nevada, MO 64772
417-667-7833; TDD 417-448-1302; FAX 417-448-1138
Chris Baker, Superintendent

POPLAR BLUFF REGIONAL CENTER
2351 Kanell Boulevard
Poplar Bluff, MO 63902
573-840-9300; TDD 573-840-9312; FAX 573-840-9311
Kim Crites, Director

ROLLA REGIONAL CENTER
105 Fairgrounds Road, P.O. Box 1098
Rolla, MO 65402
573-368-2200; TDD 573-368-2200; FAX 573-368-2206
Sandy Wise, Director

SIKESTON REGIONAL CENTER
112 Plaza Drive, P.O. Box 966
Sikeston, MO 63801
573-472-5300; TDD 573-472-5391; FAX 573-472-5308
Kim Crites, Director

SOUTHEAST MO RESIDENTIAL SERVICES
2351 Kanell Boulevard
Poplar Bluff, MO 63902
573-840-9370; TDD 573-840-9312; FAX 573-840-9373
Tony Harris, Superintendent

SPRINGFIELD REGIONAL CENTER
1515 East Pythian, P.O. Box 5030
Springfield, MO 65801-5030
417-895-7400; TDD 417-895-7430; FAX 417-895-7412
Diana Garber, Director

ST. LOUIS DDTC
211 North Lindbergh
St. Louis, MO 63141-7809
314-340-6702; TDD 314-340-6659; FAX 314-340-6724
Diana Gibbons, Acting Superintendent

ST. LOUIS REGIONAL CENTER - NORTH
(St. Louis Co.)
211 North Lindbergh
St. Louis, MO 63141
314-340-6500; TDD 314-340-6659; FAX 314-340-6666
Anita Contreras, Director

ST. LOUIS REGIONAL CENTER – SOUTH
(St. Louis City, St. Charles Co., Jefferson Co.)
3101 Chouteau Avenue
St. Louis, MO 63103
314-301-3900; TDD 314-301-3905; FAX 314-301-3904
Cindy Mueller, Director

Appendix E

CASE ASSIGNMENT

Consumer: _____ DMH#: _____

Transition Team Leader

Regional Center/Habilitation Center	Dept.	Name	Phone #	E-mail	

Transition Team Supervisor

Regional Center	Team	Name	Phone #	E-mail	

Regional Center/SB 40 Board Transition Coordinator

Regional Center	Team	Name	Phone #	E-mail	

Quality Assurance

Regional Center	Dept.	Name	Phone #	E-mail	

Regional Center Reimbursement Officer

Name	Coverage	Duty	Phone #		
		•			

Habilitation Center Social Worker

Habilitation Center	Name	Phone #	E-mail	

Other Habilitation Center Team Members

Habilitation Center	Name	Phone #	E-mail	

Appendix F

ST. LOUIS REGIONAL CENTER
DIVISION OF MR/DD

Suzanne Wells SLRC Director

PAGE: 1 of 4

POLICY NO: SLRC 5.7.2	**DEPARTMENT:** St. Louis Regional Center
ISSUE DATE: JULY 25, 1986 **REVISED:** APRIL 15, 2002 JANUARY 1, 2003	**SUBJECT:** Client NAFS Accounts

1.0 PURPOSE

1.1 To prescribe the procedure for use of Client Non-Appropriated Funds System (NAFS).

2.0 DEFINITION

A. NAFS: Non-Appropriated Funds System

B. Sub-Accounts:

1. PRS – Personal
2. SAV – Savings (for specified expenditures)
3. CAT – Care and Treatment (used by Business Office staff only)
4. BUR – Burial Insurance (used by Business Office staff only)
5. SPE – Special Account (used by Business Office staff only)
6. MED – Medical Account (Can only be used after receiving approval from Social Security Administration). (Used by Business Office staff only).

C. Forms:

1. Financial Addendum to IHP – 650-3107
2. Withdrawal Authorization (Form 46) MO 650-3484

3.0 PROCEDURES

A. A NAFS account could be established for every client who is in a community placement facility. It may also be established for other clients for whom the Service Coordinator feels that a specialized banking system is needed to provide and/or protect the well being of the individual client and her/his assets.

A NAFS account is established for a client when funds are received by SLRC on his/her behalf after he/she enters a community placement (DMH 57) facility. For non-community placement clients (no DMH 57) the Service Coordinator must contact the SLRC's Reimbursement Department to set up the account.

The St. Louis Regional Center is mandated to apply benefits an individual may receive (SSI, SSDI, Veteran's Benefits, ETC.) toward the cost of his/her residential services prior to authorizing tax money.

B. Each team supervisor will receive a monthly listing of the sub-account balances for each client and will receive a monthly listing of clients whose sub-account exceeds $500. Service Coordinators should monitor NAFS accounts for excessive funds to avoid jeopardizing eligibility for governmental benefits (i.e., Medicaid). For this purpose, the sum of Personal (PRS) and Savings (SAV) when added together should not exceed $500.

C. For clients in community placement, if the sum exceeds $500, one of the following actions will be taken:

1. The Service Coordinator may utilize the funds to meet the client's appropriate HEALTH AND SAFETY needs by completing DMH 650-3484 (Withdrawal Authorization) within thirty (30) days of receipt of the first report which shows a balance over $500.

2. Appropriate expenditures include; clothes ($400 per year), basic bed, bedding, basic personal television, cookware, dishes, towels, basic furniture, and medications not covered by Medicaid.

3. Not approved uses for NAFS expenditures include: burial policies, vacation, retreats, camp, presents, travel, registration fees, enter-tainment fees (six flags, Cardinals tickets, Symphony tickets, etc), VCR, computers, DVD players, etc.

   NOTE: In no case may funds be saved in excess of that allowed by Medicaid (999.99) if the client is otherwise eligible for the benefits

4. If action is not taken within thirty (30) days of notification (monthly report to team) and if SLRC is the payee on the benefits, accounting staff will reduce the account to $500 by applying the excess over $500 towards the care and treatment cost of the client's placement. Notification to the Service Coordinator will be done by the completion of a 650-3107 by accounting staff.

   During the last five (5) working days of each month accounting staff will review each financial folder on each client who has a total in PRS and SAV sub-accounts above $500 and will route to the Account II located in the Business Office a summary of the current

status on each client. This summary must contain at least the client's name, census status, unit, sub-account balance, and a brief action statement.

D. For sub-accounts Special (SPE) or Care and Treatment (CAT) it shall be the Business Office's responsibility to monitor these accounts at least quarterly and document the action(s) in the client's financial folder.

During the last ten (10) working days of each quarter accounting staff will review each financial folder on all clients for whom there is a balance in either the CAT or SPE sub-accounts and route to the Accountant II located in the Business Office a summary of the current status on each client. This summary must contain at least the client's name, census status, unit, sub-account balance, and a brief action statement.

E. For clients who are <u>not</u> in the community placement, the Service Coordinator shall assist the client in utilizing the funds to pay for service(s) or other need(s) and shall assure that the balance in the account does not jeopardize any benefits such as SSI ($2,000.00 maximum allowed) and Medicaid ($999.99 maximum allowed).

F. For clients who have been discharged, transferred, or have expired, accounting staff shall review the account(s) at least quarterly. During the last ten (10) working days of each quarter, accounting staff will review each financial folder on each client and route to the Accountant II located in the Business Office a summary of the current status on these clients. This summary must contain at least the client's name, census status, unit, sub-account balance, and a brief action statement.

G. Signature requirement on funds requested by SLRC staff using NAFS accounts:

Amounts less than $500 for an individual client requires**:**

1. Service Coordinator requesting the funds
2. Team Supervisor

Amounts over $500 for an individual client.

1. Service Coordinator requesting the funds
2. Team Supervisor
3. Assistant Center Director

Amounts greater than $1,000 for an individual client must have:

1. Service Coordinator requesting the funds
2. Team Supervisor

3. At least ONE OF THE FOLLOWING signatures::
   a. Assistant Center Director
   b. Center Director
   c. Eastern District Deputy Director

Receipts:

1. Original receipts will be returned to the NAFS office located at Bellefontaine Habilitation Center. This is for all NAFS withdrawals In excess of $60 per month. Receipts will be returned within ONE MONTH OF ISSUANCE.

2. Original receipts must have attached a copy of the original (Form 46).

3. Service Coordinator will document within the client's progress notes which receipts they have returned.

H. Retrochecks for SSI or SSA:

1. Retro check(s) for less than $3,000 will follow guidelines as stated in Section C.
2. SLRC is mandated to apply all benefits toward the cost of residential services, prior to authorizing tax money.

Appendix G

Division Directive Number 4.040

Effective Date: July 1, 2003

REVISION DATE: March 10, 2004

Anne S. Deaton, Ed.D., Director

Title: Referrals and discharges to and from state operated habilitation centers

Application: Applies to all Regional Centers and Habilitation Centers. An evaluation tool to analyze the effectiveness of this policy shall also be implemented and reviewed periodically.

Purpose: This policy outlines procedures and documentation requirements for Habilitation Center and Regional Center staff concerning admissions and discharges to and from Habilitation Centers, as well as documentation and meeting requirements regarding individuals while they are at the Habilitation Center.

1. Throughout this policy, the definition for "interdisciplinary team" or "team" shall be: "Those individuals (professionals, paraprofessionals, and non-professionals) who possess the knowledge, skills and expertise necessary to accurately identify the comprehensive array of the individual's needs and design a program which is responsive to those needs (ICF-MR interpretive guidelines)."
2. An individual's interdisciplinary team shall be represented by those individuals that can identify needs and design a program to meet those needs. This includes all appropriate facility staff as well as participation by other agencies serving, or those which will serve the individual when discharged, such as the regional center.
3. An "expanded" interdisciplinary team is the addition of members to the interdisciplinary team as defined in number 1 above. These members should include, but not be limited to:
   - Family advocate (if requested by the person or guardian)
   - Member of the habilitation center
   - Member of the community (i.e., representative from the Regional Advisory Council, personal advocate, other state agency)
   - Two community providers (rotated on a regular basis)
   - A SB 40 Board representative (rotated on a regular basis) if available and appropriate.
4. The duties of the Expanded interdisciplinary team shall include, but not be limited to:
   1) Identification of barriers to placement in the community (by review of information sent to and from the regional center);
   2) Development of an action plan that includes timelines for overcoming the barriers'
   3) Comment or make recommendations if, after 90 days, the placement in the community is not achieved;
   4) Conform to all HIPAA requirements related to sharing of Personal Health Information (PHI).
5. For those individuals residing in habilitation centers that would like to move to the community and their guardian and interdisciplinary team are in agreement, the habilitation

center and regional center shall give them top priority, as they may fall under the Olmstead Decision.

DOCUMENTATION NEED: The Regional Center shall track the time between the date the request to move is made to the Regional Center and the actual date the move is finalized.

6. For those individuals residing in habilitation centers whose guardians want to maintain the placement at the habilitation center, but the interdisciplinary team feels community placement would meet their needs, the team shall document the guardians' concerns leading to their decision to not consider the community.
   DOCUMENTATION NEED: Documentation as to the need for continued ICF/MR services must also occur, as this is necessary for both Habilitation Center placement, and also placement under the Home and Community Based Waiver guidelines. The regional center and habilitation center staff shall document efforts to alleviate concerns expressed by guardians, while exploring/developing viable community living options.
7. For all persons currently residing in state operated habilitation centers, the interdisciplinary team shall assess appropriate residential options at their regularly scheduled review and planning meetings, which are held at least quarterly. At the time of assessment, all residential options will be reviewed with the person and/or their guardian, as well any advocate the person or guardian may invite. The person and/or their guardian shall be notified prior to the time of all meetings, and of their right to invite an advocate of their choice. Notification of this right shall be included in information provided to a person and/or their guardian at the time of their admission to the habilitation center, and prior to any assessment or planning meetings. Assessment or planning meetings shall be scheduled to accommodate the person and/or their guardian, including evenings and weekends if needed.
8. Additionally, the interdisciplinary team shall ascertain in which of the following four categories an individual would be best described:
   1) Individual wants to move, and the interdisciplinary team and guardian are in agreement. This scenario may be covered by the Olmstead Decision.
   2) Individual could move, however some accommodations must be made, or there are barriers present. For example, community readiness must occur before successful transition can occur, or a certain skill must be further developed. It must be determined by the team if the specific situation is considered to be covered by the Olmstead Decision, and should be documented accordingly.
   3) Parents/guardians want to maintain placement at a habilitation center and are not agreeing to community options at this time.

NOTE: Individuals/guardians in the above three groups shall be notified annually of the opportunity to meet with an Informed Choice volunteer and/or Regional Center service coordinator to discuss community options and procedures for making requests to move to the community. However, individuals and/or their guardians may request to meet with an Informed Choice volunteer and/or Regional Center service coordinator at any time. It is the responsibility of the Regional Center Service Coordinator working in concert with the Habilitation Center to ensure individuals and/or their guardians understand this may occur at their choice.

   4) High Risk (health and safety), and best current option is state operated facility (additional training and supports needed, and community options need to be developed). Some examples include forensic, sexual predator, extremely aggressive, very medically compromised, etc.

NOTE: Categorization is for the Division's use only, and not something that is included into the consumer's personal plan.

9. New admissions to state operated habilitation centers shall be considered time limited, in that discharge criteria and planning must begin upon admission, unless the person is offered community services and chooses the habilitation center, community provider capacity is not immediately available, or the person has been admitted by the Court or has forensic status. Admission to the state operated habilitation center will be based on most critical need first.
10. The census of all state operated habilitation centers shall not exceed 1,467 (FY 02 funded levels of all state operated habilitation centers). Referrals may be made by the regional center at any time, but the habilitation center cannot accept an admission without the approval of the District Deputy if an individual habilitation center is at or over census.
11. A referral form and risk assessment shall be completed by the Regional Center to determine the appropriateness of the referral. Services in another state operated or private ICF/MR could be offered as an option if the person refuses community services and the habilitation center is over census, and the individual meets ICF-MR criteria. However, the regional center will be primarily responsible for finding services in the community for a person in the habilitation center if the habilitation center is at or over census.
12. Processing requests for community residential supports initiated by the habilitation center shall be the responsibility of the regional center and must be expedited.
    DOCUMENTATION NEED: The Regional Center shall document and maintain records of attempts to make referrals and barriers to those referrals, as well as referrals made. The documentation shall be reported on a monthly basis to the interdisciplinary team, who shall document the results in the personal plan review, that efforts are underway to meet an individual's determined needs in a community based setting. However, documentation that the person continues to require the ICF/MR level of care must be maintained.
13. All new admissions to state operated habilitation centers shall be reviewed by the interdisciplinary team at thirty (30) days to determine if the person has a continued need for habilitation center services. Persons admitted by Court Order, the forensic process, and persons clinically determined dangerous to themselves or others, or those for whom the person or their guardian choose the state operated habilitation center as their residence are exempt from this process. At 60 days, please refer to #19 below.
14. Each regional center shall designate a person(s) who is responsible for initiating and tracking all referrals to state operated habilitation centers. This individual shall work closely with the service coordinator or other member of the interdisciplinary team, to coordinate referrals. Additionally, the regional center Director or Assistant Director and the Superintendent or Assistant Superintendent of Habilitation for the habilitation center shall be involved in referrals to state operated habilitation centers. All referrals in and out of the state operated habilitation centers shall be coordinated in this fashion. **No other system will be utilized.**
15. Regional Center service coordinators and other appropriate staff shall participate in planning as a member of the interdisciplinary team for those individuals who are either admitted into the habilitation center under this policy, or who have been identified as being in one of the top two categories indicated in number eight (8) above.
16. In any case in which the interdisciplinary team believes the individual is able to reside in the community, but the person and/or guardian insists on the state operated habilitation center, the staff shall continue to work with the person and/or their guardian to inform them of all community options available.
    DOCUMENTATION NEED: The progress that has been made toward developing community options, or to alleviate guardian concerns shall be documented during personal plan review meetings by the interdisciplinary team. Again, it is important to continue documentation that the person continues to require an ICF/MR level of care for both the ICF placement at the habilitation center, and for the Medicaid Waiver.
17. Requests for **temporary, intensive treatment** at state operated habilitation centers shall be for **30 days only and may only be renewed one time with the recommendation of the interdisciplinary team and approval by the Regional Center Director and the**

Superintendent of the Habilitation Center. If the stay is to be longer than 60 days, see # 19 below.

18. The regional center and habilitation center staff shall work with the person and/or their guardian to make preparations for the person to transition into the community prior to or no later than the 30 day expiration time limit. The transition process is guided by best practices outlined by the division, and shall include input from direct support professionals who have supported the person during their stay at the habilitation center. Appropriate health professionals such as nurses, physicians, and Regional Center nurses, will review a person's health and safety needs prior to a move to the community and assure supports are in place to support them and minimize any transfer trauma.
    DOCUMENTATION NEED: This review will be documented in the person's file and attested to by the signature of the health professional involved. Follow along tracking jointly by the Habilitation Center and the Regional Center shall occur for six months.
19. After 60 days, the person's support needs will be reviewed by an expanded interdisciplinary team that involves the participation of the Regional Center Director and the habilitation center Superintendent or their designees. As indicated in number 3 above, the expanded interdisciplinary team should include representatives of, but not be limited to, the following:
    - Family advocate (if requested by the person or guardian)
    - Member of the support team (habilitation center representative)
    - Member of the community (i.e., representative from Regional Council, advocate, other state agency)
    - Two community providers (rotated on a regular basis)
    - A SB 40 Board representative (rotated on a regular basis) if available and appropriate.
20. **DOCUMENTATION NEED:** The expanded interdisciplinary team shall:
    - Identify barriers to placement in the community (by review of information sent to and from the regional center);
    - Develop an action plan that includes timelines for overcoming the barriers;
    - Indicate in action plan date for follow-up meeting;
    - Record types of barriers that have been raised;
    - Record the number of times the expanded team must meet;
    - Comment or make recommendations if, after 90 days, the placement is the community is not achieved, and forward the documentation to the deputy director for habilitation services, the deputy director for community services, and director of policy;
    - Document successes of removing barriers with successful community placement to share with the deputy director for habilitation services, the deputy director for community services, and director of policy; and,
    - The "expanded" interdisciplinary team shall conform to all HIPAA requirements related to sharing Personal Health Information (PHI).
21. When multiple service options are available to meet a person's needs, health and safety are the primary considerations. Choice, cost, utilization review, quality and capacity shall also be taken into consideration.
22. This policy in no way prevents individuals who are eligible for ICF/MR services and whose needs cannot be safely met in the community from remaining in the habilitation center. In addition, persons who are eligible for ICF/MR services and who choose institutional services over community services may remain in the habilitation center or transferred to another ICF/MR facility (state operated or private) that has the capacity to meet the person's needs elsewhere in Missouri, by mutual consent of the District Deputies.

Appendix H

TRANSITION PLACEMENT PROCESS CHECKLIST

(Checklist to be kept in Consumer's Placement Referral File)

Name of Consumer: _____Unit:_____Home_____

(Team member responsible for tracking transition process will Check (√) each applicable item when completed and sign initials in the comment section).

1.	□	Referring Unit ID Team Recommendation	_____ _____ Date Comments/Responsible Party
2.	□	Community Placement Options letter sent	_____ _____ Date Comments/Responsible Party
3.	□	Guardian Approval (Please attach a copy of the Community Placement Options letter & survey)	_____ _____ Date Comments/Responsible Party
4.	□	Planning Meeting	_____ _____ Date Comments/Responsible Party
5.	□	Consumer Residential Referral Form Completed & Sent to Regional Center	_____ _____ Date Comments/Responsible Party
6.	□	Transition Placement Referral Packet sent to Placement Coordinator which now includes the revised PCP, copy of completed Health Inventory, medical, nursing, psychological, social history, PT, OT, ST, BSP, educational & legal issues. Placement Coordinator sent Transition Placement Referral to all Providers (Referral only)	_____ _____ Date Comments/Responsible Party _____ _____ Date Comments/Responsible Party
7.	□	Placement Coordinator sent out to Consumer Residential Referral those providers who voiced interest notifying Habilitation Center of Providers interested so visits can be scheduled	_____ _____ Date Comments/Responsible Party
8.	□	Placement Coordinator sent out Residential Referral packet to those providers who voiced interest notifying Transition Coordinator so visits can be scheduled.	_____ _____ Date Provider/Responsible Party

9.	□	Provider Visits Scheduled	_____ _____ Date Provider/Contact Person _____ _____ Location Comments/Responsible Party _____ _____ Date Provider/Contact Person _____ _____ Location Comments/Responsible Party _____ _____ Date Provider/Contact Person _____ _____ Location Comments/Responsible Party
10.	□	Provider Chosen	_____ _____ Date Comments/Responsible Party
11.	□	Transition Meeting	_____ _____ Date Comments/Responsible Party
12.	□	Dates consumer visited proposed sites .	_____ _____ Date Attach Post Visit Review Form _____ _____ Date Attach Post Visit Review Form _____ _____ Date Attach Post Visit Review Form
13.	□	Transition Team Leader notifies Regional Center Transition Team Supervisor of community home address so case assignment can be made by the Regional Center	_____ _____ Date Comments/Responsible Party
14.	□	ISL Budget received from Agency	_____ _____ Date Comments/Responsible Party
15.	□	PCP, ISL Budget, Service Contracts & DMH 57 sent to UR for review	_____ _____ Date Comments/Responsible Party
16.	□	PCP, ISL Budget & Service Contracts Approved	_____ _____ Date Comments/Responsible Party
17.	□	Date of Closure meeting	_____ _____ Date Comments/Responsible Party

18.	□	Proposed Move date	_____ _____ Date Comments/Responsible Party
18.	□	Move date	_____ _____ Date Comments/Responsible Party
19.	□	Notice Of Placement to Business Office & other appropriate staff	
19.	□	Follow up	_____ _____ Date Comments/Responsible Party

Appendix I

Missouri Department of Mental Health
Mental Retardation/Developmental Disabilities
Consumer Residential Referral Form

Consumer Identification

Consumer Name: _____ Client ID: _____ Date of Referral: _____

About the Transition

Transition Type

- ☐ Community to Habilitation Center (Long Term)
- ☐ Community to Habilitation Center (Short Term)
- ☐ DMH Placement to Natural Home
- ☐ Habilitation Center to Community
- ☐ Habilitation Center to Habilitation Center
- ☐ Habilitation Center Community Residence to Community
- ☐ Move within Community (Provider Change)
- ☐ Natural Home to Community
- ☐ Nursing Home to Community

Olmstead? ☐ Yes ☐ No

Current Residence

- ☐ Correctional Unit
- ☐ Family Living Arrangement (FLA)
- ☐ Foster Home
- ☐ Group Home
- ☐ Habilitation Center – Privately Operated
- ☐ Habilitation Center – State Operated
- ☐ Homeless
- ☐ Hospital – Medical
- ☐ Hospital – Psychiatric
- ☐ Individual Supported Living (ISL)
- ☐ Intermediate Care Facility/MR (ICF/MR)
- ☐ Natural Home
- ☐ Nursing Home
- ☐ Residential Care Facility (RCF)
- ☐ Supported Living Arrangement (SLA)

To DMH Facility (Circle for Primary)

☐	011 Albany Regional Center	Primary?	☐	019 Sikeston Regional Center	Primary?
☐	012 Kirksville Regional Center	Primary?	☐	023 St. Louis Regional Center	Primary?
☐	013 Hannibal Regional Center	Primary?	☐	029 Central Missouri Regional Center	Primary?
☐	014 Kansas City Regional Center	Primary?	☐	007 Bellefontaine Habilitation Center	Primary?
☐	015 Joplin Regional Center	Primary?	☐	025 Developmental Disabilities Treatment Center	Primary?
☐	016 Springfield Regional Center	Primary?	☐	024 Nevada Habilitation Center	Primary?
☐	017 Rolla Regional Center	Primary?	☐	633 SEMO Residential Services	Primary?
☐	018 Poplar Bluff Regional Center	Primary?	☐	022 Higginsville Habilitation Center	Primary?
			☐	006 Marshall Habilitation Center	Primary?

Placement Type Requested

- ☐ Family Living Arrangement (FLA)
- ☐ Group Home
- ☐ Habilitation Center – Privately Operated
- ☐ Habilitation Center – State Operated
- ☐ Individual Supported Living (ISL)
- ☐ Intermediate Care Facility/MR (ICF/MR)
- ☐ Natural Home
- ☐ Nursing Home
- ☐ Residential Care Facility (RCF)
- ☐ Skilled Nursing Facility (SNF)
- ☐ Supported Living Arrangement (SLA)

Placement History

	# of Placements (i.e. 5 times)	In this Time Period (i.e. 5 years)
Family Living Arrangement (FLA)		
Group Home		
Habilitation Center – Privately Operated		
Habilitation Center – State Operated		
Individual Supported Living (ISL)		
Intermediate Care Facility/MR (ICF/MR)		
Natural Home		
Nursing Home		
Residential Care Facility (RCF)		
Skilled Nursing Facility (SNF)		
Supported Living Arrangement (SLA)		

Preferred Counties, Regions, Cities

_____

_____

Requestor

- ☐ Consumer
- ☐ Court Order
- ☐ Forensic
- ☐ Guardian
- ☐ Habilitation Team
- ☐ Olmstead Decision
- ☐ Professional Team

Provider Exceptions

Do NOT Show to these providers: _____

Show ONLY to these providers: _____

About the Transition Continued…

Financial Resources

Currently Medicaid Eligible? ☐ Yes ☐ No

Category	Financial Resource	Monthly Amount	Comments
Income	Employment		
Income	Social Security		
Income	Supplemental Security Income		
Income	Veterans Benefits		
Income	Trust Funds/Annuities		
Income	Assistance from family/friends		
Income	Bank & Savings Accounts		
Insurance	Life Insurance		
Insurance	Burial Plan		
Personal Property	Burial Lot		
Personal Property	Household Furnishings		

Legal Resources

	Full Name	Address City, State, Zip	Phone Number
Conservatorship			Home: Cell: Work:
Power of Attorney Health			Home: Cell: Work:
Power of Attorney Legal			Home: Cell: Work:
Social Security Benefit Payee			Home: Cell: Work:
Other (Describe Relationship)			Home: Cell: Work:

DMH Contacts

Name: **DMH Facility:**	**Work Phone 1:** **Work Phone 2:** **Cell Phone:** **Fax:** **E-Mail:** **Other:**	☐ HC Placement Coordinator ☐ HC Program Supervisor ☐ HC Social Worker ☐ RC Placement Coordinator ☐ RC Transition Coordinator ☐ RC Transition Supervisor ☐
Name: **DMH Facility:**	**Work Phone 1:** **Work Phone 2:** **Cell Phone:** **Fax:** **E-Mail:** **Other:**	☐ HC Placement Coordinator ☐ HC Program Supervisor ☐ HC Social Worker ☐ RC Placement Coordinator ☐ RC Transition Coordinator ☐ RC Transition Supervisor ☐
Name: **DMH Facility:**	**Work Phone 1:** **Work Phone 2:** **Cell Phone:** **Fax:** **E-Mail:** **Other:**	☐ HC Placement Coordinator ☐ HC Program Supervisor ☐ HC Social Worker ☐ RC Placement Coordinator ☐ RC Transition Coordinator ☐ RC Transition Supervisor ☐

About the Consumer

Day Activities

	Day Activity	Full Time	Part Time	Category
☐	Day Habilitation	☐	☐	Day Habilitation
☐	Vocational Training	☐	☐	Education
☐	Classroom Setting	☐	☐	Education
☐	Pre-Vocational Training	☐	☐	Education
☐	Physical Therapy	☐	☐	Therapy
☐	Speech Therapy	☐	☐	Therapy
☐	Occupational Therapy	☐	☐	Therapy
☐	Horticulture Therapy	☐	☐	Therapy
☐	Competitive Employment	☐	☐	Work
☐	Supported Employment	☐	☐	Work
☐	Sheltered Employment	☐	☐	Work
☐	Volunteer	☐	☐	Work

Daily Living Needs

	Needs Assistance	Fully Dependent
Bathing	☐	☐
Dressing	☐	☐
Grooming	☐	☐
Eating	☐	☐
Cooking	☐	☐
Toileting	☐	☐
Money Management	☐	☐
Medication Management	☐	☐

Medical Support Needs

- ☐ Allergy(s)
- ☐ Ambulatory
- ☐ Bowel Care
- ☐ Braces
- ☐ Catheterization
- ☐ Colostomy
- ☐ Dentures
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ Dialysis
- ☐ Handicap accessible environment
- ☐ Handicap accessible transportation
- ☐ Hearing - Deaf
- ☐ Hearing - Hearing Aids
- ☐ Hearing - Normal
- ☐ Hearing - Partial hearing loss
- ☐ Hearing - Unknown or undetermined hearing capabilities
- ☐ Illnesses that interfere with daily routine
- ☐ Illnesses that require medical attention
- ☐ Incontinence
- ☐ Mobility - Crawls
- ☐ Mobility - Electric wheelchair independently
- ☐ Mobility - Electric wheelchair with transfer assist
- ☐ Mobility - Lift
- ☐ Mobility - Manual wheelchair with assistance
- ☐ Mobility - Manual wheelchair with transfer assistance
- ☐ Mobility - Manual wheelchair without assistance
- ☐ Mobility - Requires total assistance with mobility
- ☐ Mobility - Walker/Cane
- ☐ Mobility - Walks independently
- ☐ Mobility - Walks unaided with difficulty
- ☐ Mobility - Walks with supportive devices
- ☐ Oxygen therapy
- ☐ Skin Breakdown
- ☐ Special Diet Preparation
- ☐ Speech - Communicates using assisted devices
- ☐ Speech - Communicates using gestures or eye pointing
- ☐ Speech - Communicates using sign language
- ☐ Speech - Difficult to understand
- ☐ Speech - No functional communication
- ☐ Speech - Normal
- ☐ Suctioning
- ☐ Therapeutic Positioning
- ☐ Tracheotomy
- ☐ Tube Feeding
- ☐ Uncontrolled seizures
- ☐ Ventilator
- ☐ Vision - Blind
- ☐ Vision - Impaired but corrected with glasses
- ☐ Vision - Impaired vision
- ☐ Vision - No functional vision
- ☐ Vision - Normal
- ☐ Vision - Travel vision but legally blind
- ☐ Vision - Unknown or undetermined visual ability
- ☐ Wears depends

Staff Support Needs

- ☐ Sign Language
- ☐ 24 Hour
- ☐ Moderate Supervision
- ☐ Line of Sight
- ☐ Awake, Overnight Staff
- ☐ Constant Supervision
- ☐ Requires RN/LPN oversight on all shifts
- ☐ Max Time Alone – Less Than 15 Minutes
- ☐ Max Time Alone – Less Than 1 Hour
- ☐ Max Time Alone – 10+ Hours
- ☐ Unable to Evacuate Without Assistance
- ☐ Max Time Alone – 1-3 Hours
- ☐ Max Time Alone – 3-10 Hours
- ☐ 1:1 Staffing
- ☐ More than 1:1 Staffing

About the Consumer Continued…

Behavioral Issues

Monitoring Needed	Protection Needed	
☐	☐	Chemical Abuse
☐	☐	Dishonesty
☐	☐	Elopement
☐	☐	Physical Aggression
☐	☐	PICA
☐	☐	Property Destruction
☐	☐	Self-Abuse
☐	☐	Sexuality
☐	☐	Sexuality (Predator - Preference Female)
☐	☐	Sexuality (Predator - Preference Male)
☐	☐	Sexuality (Predator - Children)
☐	☐	Social Interactions
☐	☐	Survival Skills
☐	☐	Verbal Aggression
☐	☐	Stealing
☐	☐	Fire Setting

Diagnosis

☐ I have checked the Diagnosis in the computer system. Include them all on the provider referral.

OR

Exclude (write in the diagnosis code): _____
Exclude (write in the diagnosis code): _____
Exclude (write in the diagnosis code): _____

Family Involvement

☐ Frequent
☐ Infrequent
☐ None

Intellectual Skills

Moderate	Serious	
☐	☐	Judgment Impairment: inability to make rational decision for health, safety, financial, etc.
☐	☐	Judgment Impairment: easily taken advantage of
☐	☐	Judgment Impairment: inability to advocate for self
☐	☐	Capacity to Recognize Reality: paranoia or delusional behaviors
☐	☐	Coping Skills of Life Demands: does not handle everyday stress
☐	☐	Coping Skills of Life Demands: does not deal with disruptions in environment

Other Narratives/Comments

Narrative Categories	Narrative Types	Comments
Day Activities	Day Hab Provider Preference	
Day Activities	Education Vocational Training	
Day Activities	School Age -District/Classroom Preference	
Financial Information	Household Furnishings	
Financial Information	Other Income	
Financial Information	Outstanding Debt	
Location Preference	Location Preferences (i.e. anything unusual not handled in preferred regions/cities/counties tabs)	
Medical	Current Medical Condition/Treatment	
Medical	Current Medications	
Medical	Current Physician and Specialists	
Medical	Medical Supplies and Equipment	
Medical	Special Training (i.e. insulin, seizures, breathing, body fluids, speech, range of motion)	
Personal Change Inventory	Life Style Changes - Anticipated Emotional (list anticipated supports/ interventions needed for transition)	
Personal Change Inventory	Life Style Changes - Anticipated Physical (list anticipated supports/ interventions needed for transition)	
Personal Change Inventory	Life Style Changes - History Emotional (List the change and impact on emotional health - successful and unsuccessful supports/interventions)	
Personal Change Inventory	Life Style Changes - History Physical (List the change and impact on emotional health - successful and unsuccessful supports/interventions)	

Personal Change Inventory	Living Environment - Health/Safety Issues (i.e environmental safeguards, fire/disaster drills, etc.)	
Other	Significant Comments	

Activity Tracking (Part 1)

For these types of transitions, fill in a date or text as indicated by the "X" below:

- Habilitation Center Community Residence to Community (Also Complete Part 2)
- Habilitation Center to Community (Also Complete Part 2)
- Nursing Home (Olmstead) to Community (Also Complete Part 2)

Activity Definition	Date	Text
Guardian Consent To Explore Options (Olmstead)	X	
Planning Meeting	X	
Written HIPAA Consent (if applicable)	X	
Health Inventory Completed	X	
Regional Center Activated Case	X	
Health Inventory Obtained by RC	X	
MoAide Invited to Speak with Consumer	X	

Activity Tracking (Part 2)

For these types of transitions, fill in a date or text as indicated by the "X" below:

- Community to Habilitation Center (Long Term)
- Community to Habilitation Center (Short Term)
- DMH Placement to Natural Home
- Habilitation Center Community Residence to Community
- Habilitation Center to Community
- Habilitation Center to Habilitation Center
- Move within Community (Provider Change)
- Natural Home to Community

Activity	Date	Text
Written HIPAA Consent (if applicable)	X	
Placement Type Selected	X	
Referral Packet (Full) Received From Service Coordinator	X	
Referral Packet (Full) Sent to Provider		X
Transition Meeting	X	
Closure Meeting	X	
Targeted Move In Date	X	
Actual Move-In Date	X	
30 Day Follow Up Completed	X	

Appendix J

Placement Referral Packet Checklist

(To be completed by the Habilitation Center and included in the Placement Referral Packet)

- Copy of Community Options Placement Consent Letter: ☐ YES ☐ NO
  Comment: _____
- Copy of revised person-centered plan: ☐ YES ☐ NO
  Comment: _____
- Copy of Certification of Medicaid Waiver eligibility diagnosis: ☐ YES ☐ NO
  Comment: _____
- Copy of Reports (Social Service, Annual Medical, physical, dental, psychological) ☐ YES ☐ NO
  Comment: _____
- Copy of Health Inventory: ☐ YES ☐ NO
  Comment: _____
- Copy of monthly/quarterly reviews: ☐ YES ☐ NO
  Comment: _____
- Copy of Crisis / Behavioral Plan (if applicable): ☐ YES ☐ NO
  Comment: _____
- Copy of current Social Security Benefits Letter: ☐ YES ☐ NO
  Comment: _____
- Copy of Guardianship Papers: ☐ YES ☐ NO
  Comment: _____
- Copy of Social Security Card: ☐ YES ☐ NO
  Comment: _____
- Copy of Medicaid card: ☐ YES ☐ NO
  Comment: _____
- Copy of Immunization Record including current T.B. screening ☐ YES ☐ NO
  Comment: _____
- Copy of Birth Certificate: ☐ YES ☐ NO
  Comment: _____
- Copy of State I.D with new address.: ☐ YES ☐ NO
  Comment: _____

- Copy of Burial Plan/Life Insurance ☐ YES ☐ NO
  Comment: _____

FORM COMPLETED BY: _____ **TITLE:** _____

SUBMITTED TO COMMUNITY PLACEMENT COORDINATOR DATE: _____

Appendix K

SB 40 Boards Serving St. Louis Region (Eastern District)

ST. LOUIS CITY

St. Louis Office for Mental Retardation
2334 Olive Blvd.
St. Louis, Missouri 63103
Director: Ms. Barbara Searight
(314) 421-0090
(Provides Service Coordination)

ST. LOUIS COUNTY

Office of Productive Living Board
121 Hunter, Suite 200
Ladue, Missouri 63124
Director: Ms. Joyce Prage
(314) 726-6016

ST. CHARLES

Developmental Disabilities Resource Board
2480 Executive Drive, Suite 208
St. Charles, Missouri 63303
Director: Ms. Peg Capo
(636) 949-9075

JEFFERSON COUNTY

Jefferson County Commission
P.O. Box 97
Mapaville, Missouri 63065
Director: Jennifer Wooldridge
(636) 931-4219
(Provides Service Coordination)

Appendix L

Residential Support Providers

Bridges Community Support 2001 S. Hanley Rd. St. Louis, MO 63144 Barry Larson (314) 781-7900 (314) 781-7914 fax	**Council for Extended Care** 5257 Shaw Ave, Suite 305 St. Louis, MO 63110 Lelia Linhorst 781-4950 771-8880 fax	**Contemporary Living Options** 4144 Lindell Blvd., Suite 318 St. Louis, MO 63108 Anetta Bolden-Roberts 535-9391 535-0064 fax
Creative Concepts for Living 7157 N. Lindbergh St. Louis, MO 63042 Dawn Schmitt Phone: (314)731-0075 Fax: (314)731-0080	**Judevine Center** 1101 Olivette Executive Pkwy St. Louis, MO 63132 Kellenne Z. Stevens Rick Goolsby (314) 432-6200 (314) 432-3059 fax	**Life Skills Foundation** 10176 Corporate Square Dr. Suite 100 St. Louis, MO 63132 Tom Bay 567-1067 567-6539 fax
Willows Way 2285 Bluestone Dr. St. Charles, MO 63303 Karrie Gates (636) 947-6591 ext. 304 (636) 947-6385 fax	**Gateways** 10650 Gateway Blvd. St. Louis, MO 63132 Melissa Kaag 997-1734 997-7303 fax	**Life Development Support Center** 12259-61 Bellefontaine Rd. St. Louis, MO 63137 Joanna Harris (314) 653-6882 (314) 652-6420 fax
St. Louis ARC 1240 Dautel St. Louis, MO 63146 Tim Bradbury or MaryAnn Tolliver 569-2492 ext. 265 569-0632 fax	**Emmaus** 2200 Randolph Street St. Charles, MO 63101 Lisa Krueger 946-6144 947-1336 fax	**United Cerebral Palsy** 8645 Old Bonhomme Rd. St. Louis, MO 63132 Linda Taylor 994-1600 994-0179 fax

Developmental Services of Jefferson Co. P.O. Box 97 Mapaville, MO 63065 Diane Burwell (636) 282-0756 ext. 10 (636) 931-8019 fax	**Hab Care** 7647 Delmar Blvd. St. Louis, MO 63130 Bill Brandt (314) 726-6939 ext. 202 726-1352 fax / 902-8395 pager	**Open Options, Inc.** 10176 Corporate Square Dr. Suite 100 C St. Louis, MO 63132 Louise Hill 567-3847 567-4752 fax
Magdala Foundation 4158 Lindell Blvd. St. Louis, MO 63108 Linda Bixter-Irwin 652-6004 652-8351	**Community Living Inc.** 8 Westbury Dr., Suite 100 St. Charles, MO 63301 Bev Moore (636) 946-3557 ext.3034 (636) 946-9347 fax	**The Hudson Group** 12540 Bayshore Dr. Florissant, MO 63033 Phil Brown (314) 569-5712 (314) 524-1232 fax
Community Alternatives MO 2570 Metro Blvd. Maryland Heights, MO 63043 Heather Bachman (314) 994-3033 ext. 202 (314) 994-9456	**SLDDTC** 211 N. Lindbergh St. Louis, MO 63141 Jerry Clubbs	**HEARTLAND SUPPORTED LIVING, INC** P.O. Box 1536 Sikeston, MO 63801 1-800-681-4837 (Fax) 573-472-4285 Contact person: Ron McCormick
Bellefontaine Habilitation Center 16095 Bellefontaine Rd. St. Louis MO 63137 Sharon Turner (314) 340-6106 (314) 340-2788 fax	**Complete Personal Services** 160 Marine Lane St. Louis, Mo. 63146 Phone: (314) 275-7611	**Cooperative Attendant Services** 1924 Marconi St. Louis, Mo. 63110 Thomas Brozka Phone: (314) 772-8585 x 324 Fax: (341) 772-2820
Pony Bird P.O. Box 190 Mapaville, MO 63065 Linda Dallas (636) 931-5818 (636) 931-3518 fax	**Children's Home Society** 9445 Litzsinger Road St. Louis, MO 63144 Rick Conaway 968-2350 968-4239	**Adapt of Missouri, Inc.** 902 Soulard Street P.O. Box 58669 St. Louis, MO 63158
Quality Care, Inc. 524 Vine St. Poplar Bluff, Mo. 63901 Beverly Kennedy Phone: (573) 686-5600 Fax: (573) 865-6000	**Everyday Life Experiences** 300 S. Grand Ave. Suite 221 St. Louis, Mo. 63103 Jackie Kelly Phone: (314) 534-7717 Fax: (314) 534-8818	**Advantage Home Care** 1329 Macklind Ave. St. Louis, Mo. 63110 Cecelia Lacey Phone: (314) 647-4010

Appendix M

DAY PROGRAMS

Aaron Psychology	(314) 275-7600
Behavioral Consultants	(314) 843-0080
Bridges Community Support	(314) 781-7900
Carter, Yolanda	(314) 385-5015
Center for Head Injury Services	(314) 426-7559
Community Alternatives	(314) 429-5208
Community Living, Inc.	(636) 946-3557
Community Opportunities	(314) 462-7695
Contemporary Living Options	(314) 535-9391
Cooperative Attendant	(314) 772-8585
Cotoneaster, Inc.	(573)334-5333
Council for Extended Care	(314) 781-4950
Creative Concepts for Living	(314) 909-0101
Developmental Services of Jefferson County	(636) 942-1311
Emmaus Day Program	(636) 433-2207
Emmaus Home, St. Charles	(636) 946-6144
Every Day Life Experiences	(314)534-7717
Gateway Homes	(314) 997-1734
Giant Steps of St. Louis	(636) 989-7884
Wendy Gilliam	(314) 383-8807
Good Shepherd	(314) 469-0606
Heartland Supported Living	(573) 471-7074
Judevine Center for Autism	(314) 432-6200
Learning Center of Life Skills	(314)729-0703
Life Development Support Centers	(314) 653-6423
Madison County Council for Developmentally Disabled	(573) 783-3770
Manchester Center for Development-Ally Disabled	(636) 391-1583
Metropolitan Employment and Rehabilitation Service	(314) 241-3464
Missouri Easter Seal Society	(314) 776-1996
Mitchell, Jennifer	(636) 566-6193
Northside Family Center	(no number listed)
Partners in Behavioral Milestones, Inc.	(816) 501-5138
Pediatric Physical Therapy	(314) 895-6167
Places for People	(314) 535-7463
Pony Bird Inc.	(636) 937-0202
Project Home	(314) 432-0625
Saddler Residential Care/Day Program	(314) 725-3709
Sontag, Fran	(314) 862-3616
South City YMCA	(314) 353-0439
St. Louis ARC	(314) 569-2211
St. Louis Office for MRDD	(314) 421-0090
Support Innovations, Inc.	(314) 205-0588
UCPA	(314) 994-1600
Warren Co. Handicapped Services	(636) 456-7518

Willows Way, Inc.	(636)947-6591

FUNDED BY MEDICAID OR MEDICAID/MEDICARE

Adapt of Missouri	(314) 644-3111
Association on Aging with Developmental Disabililities	
Independence Center	(314) 812-8675
Red Cross	(314) 771-6656
St. Elizabeth's	(314) 867-6511
SSM Health Care	(314) 768-8064
Support Innovations	(314) 839-4458

THE ALZHEIMER'S ASSOCIATION ALSO HAS A LIST OF MISSOURI ADULT DAY CARE CENTERS. THEY CAN BE REACHED AT (314) 432-3422 OR 1 (800) 980-9080.

Appendix N

Community Transition Visit Review

(This evaluation tool can be utilized to assist a consumer and/or their guardian in choosing his/her community, living environment, roommate and provider. A form should be completed after each visit so that a comparison can be done before making his/her final choice).

Date and Time of Visit: _____

Provider: _____

Address: _____

_____

Phone #: _____

Provider Representative: _____

Phone #: _____

Habilitation Center Staff Providing Supervision: _____

Transition Coordinator: _____

Consumer/Guardian/DMH Staff Comments:

Community: (what I liked, what I did not like, what I would change if I could)

_____
_____
_____
_____
_____

Living Environment: (what I liked, what I did not like, what I would change if I could)

_____
_____
_____
_____
_____

Roommate: (what I liked, what I did not like, what I would change if I could)

_____
_____
_____
_____
_____

Provider: (what I liked, what I did not like, what I would change if I could)

_____
_____
_____
_____
_____

I would like to schedule future visits with this agency and roommate

_____Yes ____No

I would like to schedule future visits with this agency but with a different roommate

_____Yes ____No

Future visits scheduled:

Date	Time	Location	Contact Person/Phone #

Revised 11/03

APPENDIX O

PLANNING/TRANSITION/CLOSURE MEETING
(CIRCLE APPROPRIATE MEETING)

Consumer: _____Unit: _____Home: _____

Name	Title	Date
Name	Title	Date
Name	Title	Date
Name	Title	Date
Name	Title	Date
Name	Title	Date
Name	Title	Date
Name	Title	Date

***Community Transition Team**
These are all the individuals who have participated in the meeting either by attending the meeting or submitting information for the person-centered plan that will direct the services and supports that are required for the consumer to transition to the community (Individual, his/her parents/guardian, Habilitation Center staff, SLRC Transition Coordinator, family, friends etc.).

Appendix P

Discharge Inventory Checklist

Consumer's Name: _____ DMH#:_____

NO.	ITEM	QUANTITY ALREADY POSSESSES	NEEDS TO PURCHASE (BY DATE)	PERSON RESPONSIBLE
1.	**Household Items**			
	1. Bed			
	2. Dresser			
	3. Mirror			
	4. Night Stand			
	5. Lamp(s)			
	6. Mattress			
	7. TV			
	8. Radio			
	9. Stereo			
	10. DVD			
	11. CD Player			
	12. Video Game(s)			
	13. Couch			
	14. Chair(s)			
	15. End/Coffee tables			
	16. Dining Room Set			
	17. VCR			
	18. Dishes			
	19. Flatware			
	20. Pots and Pans			
	21. Toaster			
	22. Skillets			
	23. Microwave Oven			
	24. Hangers			
2	**Bed/Bath Linens**			
	1. Comforter(s)			
	2. Sheets			
	3. Pillow(s)			
	4. Pillow Case(s)			
	5. Bath Towel(s)			
3.	**Personal Care Products**			
	1. Mouthwash			
	2. Deodorant			
	3. Toothpaste			
	4. Toothbrush			
	5. Comb			

Discharge Inventory Checklist
Page 2

NO.	ITEM	QUANTITY ALREADY POSSESSES	NEEDS TO PURCHASE BY (DATE)	PERSON RESPONSIBLE
	6. Brush			
	7. Soap			
	8. Razor			
4.	**Clothing**			
	1. Undergarments			
	2. Shirts			
	3. Pants			
	4. Shoes			
	5. Socks			
	6. Jacket			
	7. Gloves 8. Boots 9. Skirts/Dresses 10.Sweaters			
5.	**Medication** **(List all w/dosage)**			
6.	**Adaptive Equipment**			
7.	**Clinical Folder** • Copy of Discharge Summary • Original Medicaid Card Current MD's Orders Current Immunization Record • Additional Medical Consults			
8.	**Spending Money/**			
9.	**Start Up Money** (Goods/furniture)			
10.	**Transition Funds** (Reimbursed for visits)			

NO.	ITEM	QUANTITY ALREADY POSSESSES	NEEDS TO PURCHASE BY (DATE)	PERSON RESPONSIBLE
11.	**Miscellaneous Items**			

Habilitation Center Staff,

By signing this discharge inventory list you are stating that the above items checked have been discharged to the provider agency, accompanying the consumer to his/her new home.

_____ _____
Staff Signature/Title Date

Residential Provider Agency,

By signing this discharge inventory list you are confirming receipt of the above items checked, which have accompanied the consumer to his/her new home.

_____ _____
Provider Signature Date

Note: Copies shall be given to Provider Agency, Discharge Facility and Regional Center.

Revised 11/03

Appendix Q

St. Louis Regional Center

Guidelines for Funding Individualized Supported Living

Budgets should be authorized through and in conjunction with the entire plan year. Changes can be made throughout the year if status of staffing changes or you can use the scheduled exception category for those additional changes that occur only a few times per year.

Both sides of the budget must be completed fully and accurately.

Room and Board

Individuals will be supported to live within their income. The room and board side of budgets should be limited to the current income available to the person. **Medicaid Spenddown must be taken into account when determining an individual's available income (i.e. Benefits, Wages, etc. minus Medicaid Spend down equals available income).** Neither SLRC nor DMH will subsidize room and board costs.

When room and board costs exceed an individual's available income, the planning team must acknowledge this with a written plan of action to decrease costs to the income available to the individual.

Rent

- Copy of the lease **must** be submitted with the annual budget. Neither SLRC nor DMH will be responsible for the cost of breaking a lease. **Budgets must be approved before the agency can be assured that the individual's income can cover the cost.**
- Cost of family owned homes must be shared by family members or roommates.
- Aggressive efforts should be made by the individual and the planning team to secure affordable housing through all available resources (HUD vouchers, Section 8, etc.)

Food Expenses

- Must apply for food stamps – **documentation must be submitted with the annual budget.**
- Reduce the food budget by the awarded food stamp amount
- Higher amounts for specialized diets must be documented in the plan
- Amount will be reduced if the person uses nutritional supplements to replace meals.
- Average per month is $160.00.

Laundry Expenses

- Allowed only if Laundromat facilities are used (detergent is covered under household supplies)
- Cannot exceed $20.00 per month

Utilities (Gas, Electric, Water, Trash, Sewer)

- Gas & Electric combined should not exceed $160.00 monthly, per household.
- **Budget billing is strongly encouraged**
- If the following are not a part of a normal rental agreement:

- sewer - not to exceed $30.00 per month, per household
- water - not to exceed $30.00 per month, per household
- trash - not to exceed $20.00 per month, per household

It is the responsibility of the provider agency to assure that the individuals supported, as well as the staff are using cost efficient measures, as well as seeking out other available utility benefit programs.

Phone (Revised 5/23/03)-

- **Basic service cost only. A copy of the pages (from the monthly bill) that document the cost for basic local service only plus related taxes must be submitted with the annual budget.**
- No long distance, additional phone lines, upgrades for staff convenience or extra features will be paid by DMH.
- For individuals who have family out of town, discuss the use of calling cards and/or family providing long distance service (to be purchased by consumer/family)

Lawn Care/Snow Removal

- If there is no natural support available and is it not covered by the lease - $30.00 per month maximum allowable cost.

Pest Control

- Usually part of a normal rental agreement. Should not routinely be authorized in an ISL budget.

Personal Allowance

- Anyone who receives any type of unearned income (benefits such as SSI, SSA, RR, VA, etc.) is entitled to a minimum of $30.00 personal allowance.
- **$60.00 is the maximum personal spending that will be shown on the DMH-57 form.**
- Persons whose only income is from some type of monthly benefit (persons who do not work) are to receive $30.00 personal spending money per month. These individuals can be approved to receive up to $60.00.
- Persons whose income is some type of monthly benefit AND who have income from employment are entitled to have $30.00 from the benefit amount, for personal spending each month. If their net income from employment is $30.00 or more, minus any assessed amount on the standard means test, they cannot be approved to receive more than the $30.00 from their benefit amount. In other words, DMH will not supplement the amount of their personal spending money.
- If the net amount of income from employment is on the average less than $30.00 per month, after subtracting any amount assessed on the standard means test, DMH can supplement the amount of the person's personal allowance up to the difference between the net income and $30.00. For example – person's income from employment is $20.00; DMH can supplement personal allowance no more than $10.00 per month. The DMH 57 would show personal allowance as $40.00--- $30.00 from the benefit and $10.00 from DMH funding. The person would have their $20.00 from employment to use also, but the employment amount would not be shown on the DMH 57.
- Persons whose income is solely from employment and whose average net monthly income (minus applicable means test portion) is $60.00 or more shall not receive DMH funding to supplement their monthly personal allowance.

- Persons whose income is solely from employment and whose average net monthly income (minus applicable means test portion) is less than $60.00 may have the difference between the net monthly income and $60.00 supplemented by DMH if their plans document the need for the additional amount.
- For persons who have benefit amounts and/or earned income such that they are in spend down Medicaid, DMH will apply the amounts of their benefits (any amount over the spend down limit) and/or other income (according to Standard Means Test) to paying spend-down amounts toward covered services. This results in the person not having access to keep their benefit amounts or all of their earned income that is above the allowance amount for spend down Medicaid. **SLRC will not pay an individual's spend-down.**
- Records and receipts must be kept regarding personal allowance

Household Supplies

- Cleaning products, laundry goods, paper products and soap.
- Maximum $25.00 per person, per month

Maintenance and Household Repairs

- Routine maintenance is part of a normal rental agreement and should not be on any budget
- Repairs for damage done by an individual should be evaluated on a case by case basis, including a payment plan with the individual and/or guardian, as deemed appropriate by team and as approved by SLRC director (and UR process)

Cable; Homeowners/Renters Insurance; Cleaning/Maid Service

- Not allowable expenses on the budget.
- An individual can chose to use available income for any of these expenses (personal allowance, income from work, etc.). Friends, family or other natural supports can also pay for any of these expenses.

Friends, relatives, or other natural support persons may contribute additional funds toward any of the room and board line items, putting those items over the recommended maximums. For example, $160.00 food - $10.00 food stamps = $150.00 + family contribution of $50.00 per month = $200.00 for food each month. **However, these additional funds SHOULD NOT be listed on the budget. Any contributions from other sources should be documented in the person's plan.**

THE ROOM AND BOARD EXPENSE IS NOT A SERVICE; THEREFORE THESE LIMITS ARE NOT APPEALABLE.

II. Residential Habilitation

All items in this category must be documented and explained in the person's plan.

Community Specialist (CS)
(Requires Masters Degree or Bachelors Degree + 3 years experience in field of MRDD)

- Supervisor of Community Integration Skills Trainer. May also directly provide plan-related training to individuals with very high intense needs.
- CS provides training, quality assurance monitoring and supervision to other involved staff.
- $15.31 per hour. Max 1 hour per month unless highly specialized services are documented in the plan

Community Integration Skills Trainer (CIST)
(Requires Qualified Mental Retardation Professional - Bachelors Degree in a specific discipline and one year experience in MR/DD field)

- Supervisor of direct care staff
- $14.04 per hour. Hours must be based on need and documented in individual's plan.
- Initially, hours may be high if a person's needs require highly specialized training of direct care staff; hours should decline after an initial adjustment period.
- Position requires – coordinating the development of the person-centered plan (scheduling, facilitation and summary document), training direct care staff, monitoring implementation of outcomes, establishing information collection systems and writing monthly reviews.

(In small agencies, CIST might be the primary manager and not supervised by CS-in which case, budgets only reflect CIST hours)

Direct Care

- Hours are based on need documented in person's plan
- Individuals who require more than 16 hours of staffing cannot be supported in living alone. Staffing must be shared with one or two roommates.
- Each agency has a specific rate
- Hours must be reflected by a staffing pattern that is specific to the person.
- "Possible" days out are not allowed. Change of 57 or change in budget corrects actual need
- **Allow for known exceptions (this includes, but may not be limited to: planned vacations from work, planned days off from school, commonly recognized holidays, known surgeries which may require leave from work and/or school)**
- Need for overnight staff must be well documented and explained in the plan.
- Agency must consider less costly alternatives to overnight staff first. (Allow companion relief/companion stipend only if the cost of companion and relief companion combined is less than providing direct care overnight)
- If overnight awake staff is needed, it must be documented and explained in the plan or funding cannot be approved.

- SLRC will not approve situations where there are two lead agencies, both providing staff in one home.
- SLRC will not approve any ISL and ISLA combinations that require more than 10 hours per day of funded supports from DMH.

Travel/Mileage

- Mileage should not exceed that which is currently allowed by the federal government. The current rate is .335 cents per mile. An agency can only charge what they actually pay their employees (i.e. .20 cents on the budget, if .20 cents is what the agency pays its employees)
- Staff mileage expenses should be related to # of hours for CS/CIST as documented in person's plan, distance between agency's office and home, or if staff are providing transportation for a major activity (taking individual to/from work, school, activities).
- Mileage records must be kept

Staff Food

- This is not an allowable expense.

Chaperone Expense

- $30.00 is the maximum
- The activities in which the person wants to participate which require staff admission fees must be noted in the plan, as well as the frequency of participation.
- Monthly summaries must document the places and amounts, each month. Receipts must be kept.

Program Reinforcers

- Documentation of need and specific reinforcers must be in the person's plan.
- Positive Behavior Support Plan should be incorporated into the person's plan
- Monetary reinforcers will only be approved in conjunction with other types of reinforcers.
- Monthly summaries must document use of these funds.

Staff Training/Specialized Training

- Not allowed on the budget. CIST covers training of staff.

Nurse

- Need must be documented in the plan
- First access any available resources through Medicaid
- 1 hour of nursing = medication review and scheduling/coordinating doctor's appointments
- 2 hours of nursing = face to face visit in the person's home and monthly documentation by the nurse
- SLRC QA nurses assist in determining the number of agency nursing hours needed if more than 2 hours of nursing is requested.

Dietitian

- State plan Medicaid typically does not cover dietician services, except in the following cases: For the purpose of diabetes education or as a part of covered clinic services (during or after a visit with a primary care physician, at a clinic).
- Need must be documented in person's plan.

Emergency Alert Services

- Must be documented in person's plan and directly rated to reduction in support hours and health/safety
- Is not an allowable expense for any one receiving full-time supports.

Medicaid Copays/Medical Supplies

- See letter effective 7/1/02
- Need must be documented in person's plan
- Must complete Medicaid exceptions process
- Must represent the least costly alternative and will be listed as a separate line item on the 57
- SLRC will pay for gloves only if a person is incontinent or a known infectious disease carrier.

III. Case Coordination

A flat $200.00 case coordination fee in included on all Individualized Supported Living budgets. The agency assumes the responsibility for providing a "safety net" for the individual. Includes, but not limited to:

- Maintenance of a phone number which will be answered 24 hours and will assure a regular point of contact for the individual
- Coordination of all community supports and assures that other involved have delivered services as planned.
- Maintaining Medicaid eligibility; coordination of the annual planning meeting and writing up person-centered plan based on the planning meeting.
- Monitors overall delivery of supports, seeks additional avenues of support as needed or desired, acts as an individual's advocate
- Maintain contact with all members of person's team, including, but not limited to: family/guardians, educational staff, day program, case manager, physicians, etc.

IV. Administrative Costs

- Administrative costs are capped for all existing living arrangements.
- New development is limited to $500.00 or 15% whichever is less
- If change in provider, amount is $500.00 or 15%, whichever is less.

V. **Other**

- Total of all combined supports, shall not exceed 24 hours per day. (day/work/therapy plus residential habilitation)

- Any "other" item on the budget requires full rationale in the person's plan

Budget Changes

Budgets requiring changes need to be submitted no later than the 15th of the month **PRIOR TO SERVICE DELIVERY.** Retroactive budget payments requiring a change of 57 will be paid at 40% (Medicaid Match) if the service coordinator is not properly notified in writing within 14 days of the need. All adjustments must come through the service coordinator with the Assistant Center Director or Director's approval.

If a person misses three (3) days or less from school/work/program and requires additional staffing, a request for payment should be submitted within 14 days of the event. 100% of the costs will be reviewed for payment and upon approval a DMH 57 will be submitted to the Business Office. Between 15 and 60 days, a request for payment can be submitted and 40% of the costs will be reviewed for payment and upon approval a DMH 57 will be submitted to the Business Office. After 60 days a request will not be paid.

If a person misses more than three (3) days from school/work/program and additional staffing is required, the service provider must submit a change in budget within 14 calendar days in order for the change to be made before the next billing date. The service provider is strongly encouraged to withhold billing until the budget change has been authorized.

Appendix R

MEDICAID WAIVER
REFERRAL PACKET CHECKLIST

CONSUMER: _____

DMH ID#: _____

SLOT #: _____

SERVICE COORDINATOR: _____

INITIAL PACKET MATERIAL

____ Waiver Choice Statement

____ Slot Movement Form

____ MOCABI or Vineland

____ ICF-MR Level of Care

____ Annual Person-Centered Plan

____ Choice of Providers Statement

____ Budget

____ Notice of Placement Form

____ Standard Means Test

____ Medicaid Eligibility

____ Diagnosis input correctly in system

____ Necessary changes in transportation

Appendix S

Log of Contacts

(To be completed by Transition Coordinator)

Date	Agency and Person Contacted	Issue Discussed	Outcome
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		

Appendix T

Log of Contacts

(To be completed by Habilitation Center Staff)

Date	Agency and Person Contacted	Issue Discussed	Outcome
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		
	Agency: **Person:**		

Appendix U

Quality Enhancement Nursing Assignments

Barbara Meyer: 3101 Chouteau, St. Louis, MO 63103, 314-301-4934

Children's Home Society (Brentwood)
Creative Concepts for Living
Developmental Services of Jefferson County
Every Day Life Experiences
Judevine Center for Autism
Ponybird
Life Skills
Reliable Home Care Inc

Sandy McIntyre: 9445 Dielman Rock Island, St. Louis, MO 63132, 314-340-6508

Contemporary Living Options
Cooperative Attendant Services
Life Development Support Centers
Open Options
Services by Design dba Caring Solutions (St. Louis County)
St. Louis Developmental Disabilities Treatment Center- Community Residences
Foster Homes:
Anita Simmons Foster Home
Barbara Prince Foster Home
Ethel Marion Foster Home
Gary & Maria Taggart Foster Home
Hortense Holmes Foster Home
Gloria Powell Foster Home
Kathy LeGay Foster Home
Pearlie Wright Foster Home
Rebecca Smith Foster Home
Sheila Phillips Foster Home
Vanessa Y. Rucker Foster Home
Tyrone and Remona Gill Foster Home
Jacqueline Reed (JR Developmental Services) Foster Home
City:
Betty and William Brown Foster Home

Lisa Buckles: 119 Olympic Way, St. Peters, MO 63376 636-926-1234

Bethesda Lutheran
Children's Home Society (St. Charles Location)
Community Living Inc.
Emmaus Homes
Services by Design dba Caring Solutions (St. Charles County)
Foster Homes (St. Charles County)
Anthony Brungardt
Gertrude White

Mona Greer

Darlene Cunningham: 9445 Dielman Rock Island, St. Louis, MO 63132 314-340-6774

Bridges Community Support Services
Community Alternatives - Missouri
United Cerebral Palsy
Hab Care
Council for Extended Care
Magdala Benton Park
St. Louis ARC
Willows Way (St. Louis County & St. Charles County)
MCCB Transitions (Barfields)

ICF/MR (involvement only when requested)

Council for Extended Care (ICF-MR group home in Jefferson County)
Lafayette Habilitation Center
Magdala (4 ICF/MR group homes)

RESOURCES

Rev. Nov., 2003

WEB ADDRESSES

The Olmstead Fact Sheet
http://dmhonline.dmh.state.molus/divisions/mrdd/olmstead/factsheet.htm

Individual Rights of Persons Receiving Services from the Division of Mental Retardation and Developmental Disabilities
mrmail@mail.state.mo.us

Long Term Care
http://www.dhss.state.mo.us/showmelongtermcare/

Missouri's Medicaid Waiver for Persons with Mental Retardation and Developmental Disabilities (Fact Sheet)
http://dmhonline.dmh.state.mol.us/divisions/mrdd/proginfo/factsheet.htm

Social Security Online
http://www.ssa.gov/

How to Apply for Social Security Benefits
http://www.ssa.gov/disability.htm

Dept. of Social Services - Missouri Medicaid Program
http://www.dss.state.mo.us/dms/

Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov/medlearn/default.asp

Gateway Regional Advisory Council on Developmental Disabilities
stlgrac@inlink.com

ABLEDATA
www.abledata.com

Equal Employment Opportunity Commission
www.eeoc.gov

Great Plains Disability and Business Technical Assistance Center
www.adaproject.org

Hearink.inc (captioning services)
www.hearink.com

Job Accommodation Network
www.jan.wvu.edu
Missouri Business Leadership Network

www.mobln.org

Missouri Governor Council on Disability
www.dolir.state.mo.us/gcd

Missouri Assistive Technology Council
www.dolir.state.mo.us/matp

Missouri Rehabilitation Services for the Blind
www.dss.state.mo.us/dfs/rehab

Missouri Center for Independent Living /Benefits Specialists
www.mosilc.org

National Business Leadership Network
www.usbln.com

Office of Disability Employment Policy
www.dol.gov/odep

Ticket to Work
www.yourtickettowork.com

Community Connection
http://www.communityconnection.org

Productive Living Board for St. Louis County Citizens with Developmental Disabilities
http://www.plboard.com

The United Way
http://national.unitedway.org

Protection and Advocacy
http://www.protectionandadvocacy.com/odis.htm

NICHY – (Fact sheets on specific disabilities)
http://www.nichcy.org/disabinf.asp

MPACT
http://www.ptimpact.com/

Quality Outcomes Discussion Guide

Missouri Department of Mental Health
Division of Mental Retardation - Developmental Disabilities
Jefferson City, Missouri
Revised October 11, 2000

Rev. Nov., 2003

QUALITY OUTCOMES

OUTCOMES FOR PEOPLE:

1. **People belong to their community.**
2. **People have a variety of personal relationships.**
3. **People have valued roles in their family and in their community.**
4. **People are connected with their past.**
5. **People's communication is understood and receives a response.**
6. **People are provided behavioral supports in positive ways.**
7. **People are provided support in a manner that creates a positive image.**
8. **People express their own personal identity.**
9. **People have control of their daily lives.**
10. **People have the opportunity to advocate for themselves, for others, and for causes they believe in.**
11. **People's plans reflect how they want to live their lives, the supports they want, and how they want them provided.**
12. **People live and die with dignity.**
13. **People feel safe and experience emotional well being.**
14. **People are supported to attain physical wellness.**
15. **People are actively supported throughout the process of making major lifestyle changes.**
16. **People are supported in managing their home.**

QUALITY OUTCOMES

OUTCOMES FOR AGENCIES:

17. Action at all levels of the organization is consistent with a shared mission which is developed in response to the goals and aspirations of the people supported.

18. The agency initiates and maintains positive working relationships with other organizations within and outside the service delivery system.

19. The agency empowers staff to meet people's needs.

20. The agency regularly evaluates its success in meeting people's needs.

Outcome #1:	***People belong to their community.***

What Do We See In People's Lives?

- ◊ ***Lives as diverse & enriching as others in the community***
- ◊ ***Using community businesses, services, resources, etc.***
- ◊ ***Affiliation with religious organizations***
- ◊ ***Participating in the recreational, ethnic & cultural life of the community***
- ◊ ***Membership in associations, organizations, clubs, & informal community groups***
- ◊ ***Volunteerism, neighborhood associations***
- ◊ ***Familiarity with the community***
- ◊ ***Places make sense for the person***
- ◊ ***Places have significance to the person***
- ◊ ***Active participation rather than always being a spectator***
- ◊ ***Fits in with others in the community***
- ◊ ***Feeling of belonging***
- ◊ ***Natural support networks***
- ◊ ***Connections around values, interests, and competencies***
- ◊ ***Inclusion, full or partial participation***
- ◊ ***Personal involvement***
- ◊ ***One person at a time***
- ◊ ***Reciprocity, contribute to and receive from, give and take***
- ◊ ***Learning skills which are critical to community acceptance***
- ◊ ***Community presence***
- ◊ ***Meaningful days***
- ◊ ***Positive roles as community members***
- ◊ ***Employment opportunities***

Outcome #1: People belong to their community.

What Do We See Staff Doing?

Knowing the Person Well:	◊ *Values* ◊ *Personality, personal style* ◊ *Interests & competencies* ◊ *Likes & dislikes* ◊ *Personal preferences* ◊ *Comfort zones* ◊ *Responses to different kinds of situations* ◊ *Kinds of places and people the person likes* ◊ *Places that are important to the person* ◊ *Current skills and needed skills*
Knowing the Community Well:	◆ *Businesses* ◆ *Community life* ◆ *Organizations, associations & clubs* ◆ *Recreation* ◆ *Places of interest* ◆ *Assets & resources* ◆ *Significant places* ◆ *Key people at those places* ◆ *Community spirit & image* ◆ *Community values & norms* ◆ *Ethnic & cultural life* ◆ *Neighborhood hangouts* ◆ *Traditions* ◆ *Special events* ◆ *Skills which are important to acceptance* ◆ *Opportunities for volunteerism*
Bridging Between the Person & the Community:	◊ *Listening to the person* ◊ *Matching* ◊ *Supporting* ◊ *Adapting* ◊ *Communicating* ◊ *Transporting* ◊ *Planning, structuring* ◊ *Social engineering* ◊ *Teaching* ◊ *Connecting* ◊ *Fading* ◊ *Developing natural supports* ◊ *Building roles as community member*

Outcome #1: People belong to their community.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***By going with people when they go to do things & by watching their level of involvement*** ◊ ***By looking at their photo albums with people*** ◊ ***By looking at mementos from trips & special occasions*** ◊ ***By comparing how they are supported in doing things with how others in the community do them***
In People's Conversation:	◆ ***By talking with people about what they do*** ◆ ***By listening to people talk with others about what they do*** ◆ ***By talking with people about what they enjoy in the community*** ◆ ***By gauging their familiarity with the community***
Staff:	◊ ***By talking with staff about what people do and about how they support this*** ◊ ***By learning how decisions are made about where to go and what to do*** ◊ ***By watching how staff support the person in the community*** ◊ ***By hearing how they plan what supports will be needed*** ◊ ***By talking with staff about the community*** ◊ ***By talking with staff about how they build natural supports and fade specialized supports*** ◊ ***By finding out how staff are supported in learning to assist people in becoming members of the community***
Personal Plans:	◆ ***By reading the plan and talking about it with the person*** ◆ ***By looking at the plans for how support or training will be provided*** ◆ ***By looking at reviews, data, etc., related to the plan*** ◆ ***By looking for concrete action steps which will lead to real community membership*** ◆ ***By reading reviews*** ◆ ***By seeing if the plan is revised when needed***

Outcome 1: People belong to their community.

How Do We Determine If the Outcome Is Present? Chart Continued . . .

How Do We Determine If the Outcome Is Present?	
Other Documentation:	◊ ***By looking at calendars of past events*** ◊ ***By looking at logs*** ◊ ***By looking at agency mission & goals*** ◊ ***By reviewing staffing patterns***
In the Community:	◆ ***Driving Around the Community*** ◆ ***Noticing the appearance of people in various locations*** ◆ ***Getting Local Papers*** ◆ ***Watching Local News*** ◆ ***Reading Bulletin Boards in Local Businesses***

Outcome #2:	***People have a variety of personal relationships.***

What Do We See In People's Lives?

- ***Friends***
- ***Family***
- ***Acquaintances***
- ***Allies***
- ***Co-workers***
- ***Intimacy***
- ***Talking with friends & family***
- ***Regular contact with others***
- ***Going to each other's homes***
- ***Going out together***
- ***Involvement***
- ***Having information about others***
- ***Celebrating special occasions (cards, gifts)***
- ***Doing things with others***
- ***Sharing***
- ***Give and take***
- ***Caring, loving, belonging***
- ***Stories about experiences together***
- ***Private jokes & nicknames***
- ***Closeness, empathy***
- ***Natural support***

Outcome #2: People have a variety of personal relationships.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Important people in the persons life*** ◊ ***Types of people the person enjoys being with*** ◊ ***Kinds of things the person enjoys doing with different people*** ◊ ***Personal preferences*** ◊ ***Personal values*** ◊ ***Personal interests*** ◊ ***Competencies***
Knowing Others in the Person's Life & in the Community Well:	◆ ***Where people live & how to contact them*** ◆ ***Where people with different interests "hang out" in the community*** ◆ ***Special occasions to celebrate*** ◆ ***Social mores & etiquette***
Bridging Between the Person & Others in their Life & in the Community:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Making positive introductions*** ◊ ***Matching*** ◊ ***Supporting*** ◊ ***Communicating*** ◊ ***Inviting*** ◊ ***Involving*** ◊ ***Reciprocating*** ◊ ***Supporting celebration*** ◊ ***Including*** ◊ ***Welcoming*** ◊ ***Connecting*** ◊ ***Sustaining existing relationships*** ◊ ***Nurturing new relationships*** ◊ ***Fading*** ◊ ***Building natural supports***

Outcome #2: People have a variety of personal relationships.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***By observing whether the home environment is welcoming and would be a comfortable place for the person to have visitors*** ◊ ***By looking at photo albums, scrapbooks, and wallet photos*** ◊ ***By looking at cards, letters, & other correspondence with the person*** ◊ ***By looking at their personal calendar with the person*** ◊ ***By looking at their address book with the person***
In People's Conversation:	◆ ***By listening to people share stories & other information about family and friends*** ◆ ***By listening to people talk about people they know*** ◆ ***By listening to people talk about how they celebrate with others*** ◆ ***By talking with people about who they do things with and what they do*** ◆ ***By talking with people about when they last visited or talked with family and friends*** ◆ ***By listening to people talk about intimate relationships*** ◆ ***By learning if the person is lonely*** ◆ ***By talking about how often friends and family come over for a visit and what they do while they are there*** ◆ ***By hearing about dates***
From Staff:	◊ ***By talking with staff about who the person knows and about how they support existing relationships*** ◊ ***By learning how staff introduce the person to others and about how decisions are made about who to introduce the person to*** ◊ ***By talking with staff about their relationship with others the person knows*** ◊ ***By watching how staff support the person*** ◊ ***By finding out whether the person has repeated opportunities to see the same people so that relationships can develop*** ◊ ***By talking with staff about policies and practices around visitors*** ◊ ***By talking with staff about how they support the person in dating*** ◊ ***By learning whether supports are provided a person at a time or in groups*** ◊ ***By learning about how often friends and family visit the person and hearing about what they do during the visit*** ◊ ***By finding out how staff are supported in learning how to assist people in developing relationships***

Outcome #2: People have a variety of personal relationships.

How Do We Determine If the Outcome Is Present? Chart Continued . . .

How Do We Determine If the Outcome Is Present?	
Personal Plans:	◆ ***By determining who was at the planning meeting(s)*** ◆ ***By reading the plan and seeing whether it refers to others in the person's life*** ◆ ***By seeing who's involved in supporting the person*** ◆ ***By looking at the plan to determine whether attempts are being made to nurture existing relationships*** ◆ ***By looking at the plan to see how the person will be introduced to new people*** ◆ ***By looking for strategies to build new friendships*** ◆ ***By reading reviews*** ◆ ***By seeing if the plan is revised when needed***
Other Documentation:	◊ ***By looking at logs & calendars of past events*** ◊ ***By looking at policies on visitors and dating*** ◊ ***By looking at correspondence in the record from friends or family members***
In the Community:	◆ ***By looking for groups of "regulars" in local restaurants & stores*** ◆ ***By looking in the paper, phone book, or local bulletin boards for places people meet, clubs, organizations, etc.*** ◆ ***By driving around the area and looking for nearby places where people might meet others or do things together***

Outcome #3:	***People have valued roles in their family and in their community.***

What Do We See In People's Lives?

- ***Family roles***
- ***Community roles in clubs, organizations, & associations***
- ***Roles associated with personal values, interests, & competencies***
- ***Roles in religious, ethnic, and cultural organizations***
- ***Roles associated with athletic teams or sporting events***
- ***Roles associated with work, volunteerism or education***
- ***Roles associated with your home and neighborhood***
- ***Involvement with others around roles***
- ***Communication with others around roles***
- ***Possessions associated with roles***
- ***Apparel appropriate to the role***
- ***Responsibilities, duties***
- ***Commitments, obligations***
- ***Purpose***
- ***Meaning***
- ***Respect***
- ***Personal worth***
- ***Competence, decision making***
- ***Importance***

Outcome #3: People have valued roles in their family and in their community.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Personal values*** ◊ ***Competencies*** ◊ ***Interests*** ◊ ***Personal preferences, likes & dislikes*** ◊ ***Roles that the person already has which could be expanded*** ◊ ***Skills the person already has that are needed in various roles*** ◊ ***How the person wants to be supported in fully or partially carrying out existing and new roles*** ◊ ***Schedule the person will have to keep to meet time commitments***
Knowing Existing & Potential Roles Well:	◆ ***Opportunities in the community for new roles*** ◆ ***Responsibilities & accouterments of current, expanded, & new roles*** ◆ ***Knowing skills required by current, new, & expanded roles*** ◆ ***Availability of new roles in the community*** ◆ ***Knowing what possessions and apparel are required by the role*** ◆ ***Commitments and responsibilities related to current roles which will require support and potential commitments related to new or expanded roles*** ◆ ***Ways to expand existing roles and to find new ones*** ◆ ***Ways to schedule staff time to meet the person's time commitments***
Bridging Between the Person & the Role:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Exploring potential roles*** ◊ ***Social engineering*** ◊ ***Supporting, planning*** ◊ ***Teaching*** ◊ ***Sustaining & expanding existing roles*** ◊ ***Connecting*** ◊ ***Matching*** ◊ ***Fading*** ◊ ***Building natural supports***

Outcome #3: People have valued roles in their family and in their community.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***By going with people when they go to do things*** ◊ ***By looking at photo albums, scrapbooks, and other mementos*** ◊ ***By seeing possessions associated with their roles***
In People's Conversation:	◆ ***By listening to them describe their relationships and their roles within their family, groups or organizations*** ◆ ***By talking with them about the responsibilities and obligations they have*** ◆ ***By listening to them describe what they do to carry out their roles, what their duties are*** ◆ ***By talking with them about things they have to have to carry out their roles*** ◆ ***By talking with people about how they get to and from meetings or functions*** ◆ ***By talking about whether the person always goes to the meetings or functions, and if not, why not*** ◆ ***By hearing people talk about the things they might like to try***
From Staff:	◊ ***By talking with staff about the roles people are in and how they support this*** ◊ ***By learning how staff support people in finding new roles or in expanding existing roles*** ◊ ***By talking with staff about what people have to do and have to carry out roles and about how they support this*** ◊ ***By talking with staff about how they support the person in understanding the commitments and responsibilities associated with various roles*** ◊ ***By talking with staff about how they support the person in meeting the obligations of various roles*** ◊ ***By finding out whether people always go to the meetings or functions associated with their roles, and if not, why not*** ◊ ***By finding out how people go to and from their meetings*** ◊ ***By finding out how scheduling and staffing are handled so that the person can keep their commitments*** ◊ ***By asking how staff are supported in learning how to support people in finding and fulfilling roles***

Outcome #3: People have valued roles in their family and in their community.

How Do We Determine If the Outcome Is Present? Chart Continued . . .

How Do We Determine If the Outcome Is Present?	
Personal Plans:	◆ ***By reading the plan and talking about it with the person*** ◆ ***By looking at the plan for how support and training associated with roles will be provided*** ◆ ***By looking at the plan to see how existing roles are expanded and new ones are developed*** ◆ ***By reading reviews*** ◆ ***By seeing whether the plan is revised as needed***
Other Documentation:	◊ ***By looking at calendars*** ◊ ***By reading logs*** ◊ ***By looking at the agency's mission*** ◊ ***By looking at staff training curricula or training logs***
In the Community:	◆ ***By getting the local paper*** ◆ ***By reading bulletin boards in local businesses***

Outcome #4:	***People are connected with their past.***

What Do We See In People's Lives?

- ***Roots***
- ***Enduring relationships***
- ***Cultural heritage***
- ***Ethnic ties***
- ***Spiritual foundation***
- ***Continuity***
- ***Stability, permanence***
- ***Traditions, rituals, & customs***
- ***Special foods or activities associated with special occasions***
- ***Personal life stories***
- ***Enriched memories***
- ***Scrapbooks commemorating the past***
- ***Pictures from the past***
- ***Memorabilia***
- ***Places to go back to***
- ***Conversation about where they used to live***
- ***Family background***
- ***Talking about personal history***
- ***Awareness of medical history***
- ***Past trauma or losses***

Outcome #4: People are connected with their past.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Personal history*** ◊ ***Prior work & educational history*** ◊ ***Medical history*** ◊ ***Traditions & rituals*** ◊ ***Traumas & fears*** ◊ ***Past accomplishments*** ◊ ***Things used to enjoy*** ◊ ***Past roles*** ◊ ***Past friendships*** ◊ ***Family members*** ◊ ***People they used to live with*** ◊ ***Staff from other places they had close relationships with*** ◊ ***Past religious affiliations***
Knowing the Person's Past:	◆ ***Researching the past*** ◆ ***Locating people*** ◆ ***Finding out about where people have lived*** ◆ ***Exploring the person's past accomplishments and skills***
Bridging Between the Person & their Past:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Re-Uniting people*** ◊ ***Exploring together*** ◊ ***Telling stories*** ◊ ***Building memories*** ◊ ***Chronicling the past*** ◊ ***Re-establishing skills and interests***

Outcome #4: People are connected with their past.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***Looking at old snapshots with the person*** ◊ ***Looking at scrapbooks & memorabilia with the person*** ◊ ***Looking at letters, cards, and diaries with the person***
In People's Conversation:	◆ ***Talking with the person about where they've lived and who they knew when they were there and whether they still have contact*** ◆ ***Talking with people about the things they used to do well or used to enjoy doing*** ◆ ***Talking with people about where they've worked & where they went to school*** ◆ ***Talking with people about past accomplishments*** ◆ ***Talking with people about traditions in their family*** ◆ ***Learning about past religious affiliation*** ◆ ***Learning about the kinds of places the person used to live (ex., farm, inner city)***
From Staff:	◊ ***Talking with staff about where people used to live and who they knew there*** ◊ ***Talking with staff about things the person is afraid of or about past trauma*** ◊ ***Finding out how staff learn about the person's past and how they convey this to the person*** ◊ ***By learning how staff support the person in carrying on traditions that are important to them*** ◊ ***Learning how staff support the person in re-affiliating with religious organizations, if desired*** ◊ ***Talking with staff about how they support the person in re-establishing old relationships, if desired*** ◊ ***Learning about how staff support the person in re-assuming old roles, using skills they used to use, and doing things they used to enjoy***
Personal Plans:	◆ ***By seeing whether there are strategies to re-connect the person to their past, if appropriate*** ◆ ***By determining whether there are opportunities to explore past interests and use competencies*** ◆ ***By looking for strategies to re-unite people, if appropriate*** ◆ ***By reading reviews***
Other Documentation:	◊ ***Reading about the person's personal and medical history in their record***

Outcome #5:	People's communication is under-stood and receives a response.

What Do We See In People's Lives?

- ***Communicates for self***
- ***Communicates freely with others***
- ***Encouraged to communicate***
- ***Continuous opportunities to communicate***
- ***Environment promotes communication***
- ***Listened to***
- ***Communication is respected***
- ***Communication is reciprocal, ongoing, and interactive***
- ***Verbal & non-verbal communication responded to***
- ***Intent of communication understood***
- ***Staff use the person's language or understand their means of communication***
- ***The person has an effective means of communication***
- ***The person has an effective means of indicating choice***
- ***Communication needs addressed with a sense of urgency***
- ***Adaptive equipment is with the person at all times***
- ***Person & staff know how to use the person's adaptive equipment***
- ***Repair or replacement of adaptive equipment occurs quickly, respecting the person's sense of urgency***
- ***Functional alternatives used consistently when primary means not available***
- ***Communication charts (personal dictionaries) that include what staff should do in response to the person's communication***
- ***Others translate respectfully, when needed***

Outcome #5: People's communication is understood and receives a response.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Knowing how the person communicates*** ◊ ***Knowing what the person does and does not like to talk about*** ◊ ***Knowing who the person likes to talk with*** ◊ ***Understanding the person's means of communication or language*** ◊ ***Understanding the person's non-verbal communication*** ◊ ***Knowing what equipment is prescribed and how it works*** ◊ ***Understanding the conditions under which the person is most likely to have a comfortable conversation*** ◊ ***Identifying things that the person needs a way to communicate***
Knowing the Importance of Communication, In General & Its Importance In the Community:	◆ ***Knowing what communication will be required of the person in various settings*** ◆ ***Knowing what communication alternatives might work best for the person in different community settings*** ◆ ***Understanding communication provides the person with a vehicle for making choices, assuming control, dealing with frustration, etc.*** ◆ ***Understanding the urgency of addressing communication issues*** ◆ ***Understanding the importance of communication to community membership*** ◆ ***Looking for ways to make the agency settings more conducive to communication***
Bridging Between the Person & the Community:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Responding to the person*** ◊ ***Conversing with the person*** ◊ ***Translating*** ◊ ***Communication Charting or Mapping*** ◊ ***Teaching*** ◊ ***Supporting*** ◊ ***Adapting*** ◊ ***Planning*** ◊ ***Introducing*** ◊ ***Including*** ◊ ***Advocating***

Outcome #5: People's communication is understood and receives a response.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***Use of adaptive equipment as an extension of the person*** ◊ ***Rapid replacement or repair of adaptive equipment*** ◊ ***Equipment is clean and well maintained*** ◊ ***Functional alternatives available*** ◊ ***Comfort in talking with others*** ◊ ***Observing the responses of staff and others to the person's communication*** ◊ ***Finding out how easy it is to carry on a conversation in the environment*** ◊ ***Watching how staff support the person in interactions with others at home and in the community*** ◊ ***Observing how staff communicate with the person*** ◊ ***Finding out whether the person is learning communication methods and skills which are functional in the community*** ◊ ***Listening to how staff communicate with the person*** ◊ ***Observing interactions between staff and the person and between the person and others*** ◊ ***Observing staff's familiarity with the person's equipment or language***
In People's Conversation:	◆ ***Talking with the person*** ◆ ***Listening to the person communicate with others*** ◆ ***Observing the person's use of non-verbal communication*** ◆ ***Finding out what the person has to talk about*** ◆ ***Finding out if the person chose the type of adaptive equipment***
From Staff:	◊ ***Talking with staff about how they support the person in communicating with others in the community*** ◊ ***Coming to understand the emphasis staff place on communication and on equipment*** ◊ ***Understanding the emphasis they place on understanding the person*** ◊ ***Learning whether staff understand the importance of learning functional communication methods and skills to community membership*** ◊ ***Talking with staff about time lags in repair/replacement of equipment*** ◊ ***By talking with staff about how the environment promotes communication*** ◊ ***By finding out how staff learn about the person's equipment and how they learn the person's language (e.g., sign language)***

Outcome #5: People's communication is understood and receives a response.

Where and How We Look for Evidence? Chart Continued . . .

How Do We Determine If the Outcome Is Present?

Personal Plans:	♦ ***Looking for communication maps or charts*** ♦ ***Looking for recommendations for adaptive equipment & therapy*** ♦ ***Looking for goals about the use of functional communication methods & skills*** ♦ ***Reading reviews*** ♦ ***Seeing whether plans are revised when needed***
Other Documentation:	◊ ***Looking for evidence of staff training in sign language or the use of adaptive equipment, if appropriate*** ◊ ***Looking at notes & logs to see how long people go without adaptive equipment*** ◊ ***Looking at incident reports during the time people are without equipment*** ◊ ***Looking for therapists' recommendations for therapy and equipment***

Outcome #6:	***People are provided behavioral supports in positive ways.***

What Do We See In People's Lives?	
	◊ ***Meaningful lifestyle which respects personal preferences*** ◊ ***Being around others where there are positive interactions*** ◊ ***Environment and scheduling arranged to promote positive interactions*** ◊ ***Freedom to disagree & to share feelings*** ◊ ***Dealing with feelings effectively*** ◊ ***Disagreements handled constructively*** ◊ ***Integrated & included*** ◊ ***Communicative intent of behavior understood*** ◊ ***Learning skills which provide a functional alternative to the use of the "behavior"*** ◊ ***Consequences which are typical for others and for the situation*** ◊ ***Attempts to support changing behavior are made when it is important to the person*** ◊ ***Primary goal of intervention is to support the person in reaching personal goals*** ◊ ***Behavioral interventions make sense to the average person*** ◊ ***Any intervention carefully considers issues related to the person's disability*** ◊ ***Proactive protection of rights including aggressive due process*** ◊ ***Medications (especially in the case of polypharmacy) are used only when necessary and then with great care*** ◊ ***Physical & mechanical restraint are used only if absolutely necessary to prevent harm to self or others and are never used to "teach"*** ◊ ***Techniques prohibited by the Division of MR/DD are not used***

Outcome #6: People are provided behavioral supports in positive ways.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Understanding the communicative intent of behavior*** ◊ ***Nature and purpose of the behavior*** ◊ ***Personal preferences*** ◊ ***Issues associated with the person's disability*** ◊ ***Skills the person has to communicate disagreement, discomfort, anger, frustration, etc.*** ◊ ***Things the person really enjoys*** ◊ ***Types of situations the person is comfortable in*** ◊ ***Things the person really does not like*** ◊ ***Understanding whether it is important to the person to change the behavior*** ◊ ***Lifestyle variables which may be effecting behavior*** ◊ ***Medical or psychiatric reasons for behavior***
Knowing the Community & the Person's Other Environments Well:	◆ ***Awareness of various community settings*** ◆ ***Characteristics of various settings in the community*** ◆ ***Requirements of various settings in the community*** ◆ ***Characteristics of the person's home, job, and other settings*** ◆ ***Requirements of the person's home, job, and other settings*** ◆ ***Functional alternatives***
Bridging Between the Person & the Community and the Person's Other Environments:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Responding to the person*** ◊ ***Planning, structuring*** ◊ ***Social engineering*** ◊ ***Teaching*** ◊ ***Adapting*** ◊ ***Advocating*** ◊ ***Analyzing*** ◊ ***Understanding contributing factors*** ◊ ***Hypothesizing*** ◊ ***Structuring positive environments*** ◊ ***Supporting a meaningful lifestyle***

Outcome #6: People are provided behavioral supports in positive ways.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***By watching interactions between the person and staff and between the person and others*** ◊ ***By observing whether the person continues to be involved in the community*** ◊ ***By observing any intervention which might occur*** ◊ ***By observing whether there are rights restrictions or limitations*** ◊ ***By observing whether others in the setting interact in positive ways*** ◊ ***By determining whether there are issues around sharing control*** ◊ ***By determining whether the person is in a positive, reinforcing environment*** ◊ ***By seeing if the person is leading a meaningful life***
In People's Conversation:	◆ ***By talking with the person about their plan*** ◆ ***By talking with the person about what they are learning*** ◆ ***By talking with the person about previous incidents*** ◆ ***By hearing the person describe their feelings about various things*** ◆ ***By discussing their medications with them*** ◆ ***By talking with them about any rights restrictions or limitations*** ◆ ***By hearing about their life***
From Staff:	◊ ***By talking with staff to determine why they felt intervention was necessary*** ◊ ***By talking with staff about how they support the person*** ◊ ***By talking with staff about how the person's rights are protected*** ◊ ***By determining what functional alternatives staff considered*** ◊ ***By talking about the communicative intent of the behavior*** ◊ ***By talking with staff about the use and frequency of restraint*** ◊ ***By talking about the reasons medications are prescribed and any evidence of side effects*** ◊ ***By finding out about any medical or psychiatric reasons for behavior***

Outcome 6: People are provided behavioral supports in positive ways.

How Do We Determine If the Outcome Is Present? Chart Continued . . .

How Do We Determine If the Outcome Is Present?	
Personal Plans:	♦ ***By looking for positive approaches*** ♦ ***By determining whether lifestyle variables are considered*** ♦ ***By looking for evidence that the person's rights are proactively protected in preparation for and throughout any behavioral intervention*** ♦ ***By determining whether there was aggressive due process*** ♦ ***By seeing whether functional alternatives are taught*** ♦ ***By determining whether the communicative intent of the behavior is understood*** ♦ ***By determining whether changing the target behavior will benefit the person*** ♦ ***By determining whether issues associated with the person's disability have been considered*** ♦ ***By seeing whether strategies in the plan meet the common sense, "Man on the Street" test*** ♦ ***By looking at monthly reviews, training plans, and other documentation associated with the person's plan*** ♦ ***By determining if and how medication is used and reviewed.*** ♦ ***By determining whether restraint is used and under what conditions, how and by whom*** ♦ ***By determining whether any prohibited techniques are used*** ♦ ***By seeing whether the plan is revised when needed***
Other Documentation:	◊ ***By reading incident reports*** ◊ ***By reading the agency's policies on rights & due process*** ◊ ***By reviewing the agency's policy on behavioral support and restraint*** ◊ ***By reviewing staff training logs and curriculum*** ◊ ***By reviewing MARs and doctor's orders with relation to the use of behavior modifying medications*** ◊ ***By learning about the person's diagnosis and determining whether there are related considerations which might effect behavior***

Outcome #7:	**People are provided support in a manner that creates a positive image.**

What Do We See In People's Lives?

- ◊ ***Portrayed in the best light to others in the community***
- ◊ ***Avoiding stereotypical dress, hairstyle, places, & activities***
- ◊ ***Positive personal appearance***
- ◊ ***Project a positive impression***
- ◊ ***Image of personal worth and competence***
- ◊ ***Pride in accomplishments***
- ◊ ***Core belief that the person is valued and capable***
- ◊ ***Engaged in valued, positive activities***
- ◊ ***Being alone or in small groups when in the community***
- ◊ ***Spends the majority of time in integrated settings***
- ◊ ***Locations are valued and reflect positively on the person***
- ◊ ***Home and yard well maintained and typical of others in the area***
- ◊ ***Buildings owned or leased by the agency well maintained and typical of others used for the same purpose***
- ◊ ***Age appropriateness in interactions, settings, and activities***

Outcome #7: People are provided support in a manner that creates a positive image.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Personal preferences*** ◊ ***Accomplishments*** ◊ ***Capabilities*** ◊ ***Interests***
Knowing the Community Well:	◆ ***Places and activities which are seen as positive or valued in the community*** ◆ ***Types of clothing and hairstyles which are seen positively and are appealing*** ◆ ***Knowing what people of different age groups do in the community and where & when they do it*** ◆ ***Stereotypes associated with disability held by community members*** ◆ ***Knowing what's expected in various areas of town in terms of upkeep of property, landscaping, etc.***
Bridging Between the Person & the Community:	◊ ***Understanding the importance of image & impressions*** ◊ ***Supporting the person in building a positive image through appearance*** ◊ ***Supporting the person in connecting with valued activities*** ◊ ***Sharing the person's accomplishments with others*** ◊ ***Modeling respect in all interactions*** ◊ ***Supporting the person in conveying their merit or worth*** ◊ ***Supporting the person in avoiding stereotypical images in appearance, activities, and places*** ◊ ***Assuring that home, grounds, and other buildings owned or leased by the agency are well maintained and typical of others in the area***

Outcome #7: People are provided support in a manner that creates a positive image.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***By looking at where people live and how their home is maintained*** ◊ ***By observing how people dress and wear their hair*** ◊ ***By finding out where people go and what they do*** ◊ ***By going out with them and watching their interactions with others*** ◊ ***By observing what people take with them when participating in community activities and events and how they dress to determine whether the person is imaged positively*** ◊ ***By observing the person's demeanor*** ◊ ***By looking at scrapbooks of past activities*** ◊ ***By looking at photographs of the person*** ◊ ***By looking for stereotypical imaging*** ◊ ***By observing age appropriateness of settings, activities, times of day, etc.*** ◊ ***By observing whether people are primarily in segregated settings and whether time spent in the community is in large groups***
In People's Conversation:	◆ ***By listening to how people talk about themselves*** ◆ ***By hearing about the things the person takes pride in*** ◆ ***By hearing conversations between the person and staff and between the person and others***
From Staff:	◊ ***By learning whether staff understand the importance of the image the person conveys*** ◊ ***By talking with staff about how they support the person in building a positive image*** ◊ ***By finding out what staff value about the person and what they think the person can be proud of*** ◊ ***By talking with staff about how and why decisions are made about owning or leasing the buildings that they do in the locations they are in*** ◊ ***By talking with staff to learn if they know the culture of the community***

Outcome #7: People are provided support in a manner that creates a positive image.

How Do We Determine If the Outcome Is Present? Chart Continued . . .

How Do We Determine If the Outcome Is Present?	
Personal Plans:	♦ ***By reading plans to determine what types of things people are involved in*** ♦ ***By looking at support or action plans to determine how support will be provided in various community settings so that people are imaged positively*** ♦ ***By reading reviews*** ♦ ***By seeing whether plans are revised when needed***
Other Documentation:	◊ ***By reading logs*** ◊ ***By looking at materials published by the agency for fund raising and public relations purposes*** ◊ ***By looking at other brochures or materials used by the agency to present to others***
In the Community:	♦ ***By reading the local paper or talking with people in the community and finding out what things are important in the community*** ♦ ***By looking at where agency facilities are located and how they are maintained with relation to others in the area*** ♦ ***By looking at vehicles operated by the agency***

Outcome #8:	***People express their own personal identity.***

What Do We See In People's Lives?

- ***Personal style***
- ***Gender identity***
- ***Ethnicity***
- ***Cultural interests***
- ***Religious affiliation***
- ***Political affiliation***
- ***Self-expression***
- ***Music, books, magazines, movies***
- ***Creative outlets, collections***
- ***Hobbies, crafts***
- ***Following certain sports or teams, being a fan***
- ***Pets, plants, nature, bird watching***
- ***Individuality, distinct from others***
- ***Personality traits***
- ***Mannerisms & characteristics***
- ***Values & beliefs***
- ***Dress & general appearance***
- ***Decorations that reflect personal identity***
- ***Personal touches***
- ***Use of free time***

Outcome #8: People express their own personal identity.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Personality*** ◊ ***Characteristics that make the person unique*** ◊ ***Kinds of things people enjoy*** ◊ ***Type of music, movies, books, magazines*** ◊ ***Hobbies, crafts, collections*** ◊ ***Religious & political affiliations*** ◊ ***Ethnic & cultural interests*** ◊ ***Creative outlets (painting, poetry, sculpture)*** ◊ ***Athletic teams or sports*** ◊ ***Values & beliefs*** ◊ ***Likes & dislikes*** ◊ ***Recognizing & respecting individual differences***
Knowing the Community Well:	◆ ***Knowing where there are others who share the same interests & beliefs*** ◆ ***Opportunities in the community to express interests*** ◆ ***Awareness of various religious, political, ethnic, and cultural groups or events*** ◆ ***Opportunities to express identity at home (decoration, etc.)***
Bridging Between the Person & the Community:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Supporting*** ◊ ***Connecting*** ◊ ***Teaching*** ◊ ***Encouraging*** ◊ ***Exploring***

Outcome #8: People express their own personal identity.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***By observing the person's appearance & style of dress*** ◊ ***By observing decorations & personal touches*** ◊ ***By seeing evidence of hobbies or other interests*** ◊ ***By observing whether everyone in a congregate setting does all of the same things, has all of the same tapes or compact discs, wears similar clothes, etc.*** ◊ ***By developing a sense of what makes the person a unique individual*** ◊ ***By observing gender identity*** ◊ ***By finding out whether people have keys, receive mail, have a personal address book, or identification card***
In People's Conversation:	◆ ***By talking with the person about their interests*** ◆ ***By learning about what is important to the person*** ◆ ***By finding out what kinds of movies, music, and food the person likes*** ◆ ***By learning what the person likes to do with their free time*** ◆ ***By finding out what their favorite possessions are*** ◆ ***By learning about their ethnic and cultural interests and their religious affiliation***
From Staff:	◊ ***By talking with staff about the person's interests*** ◊ ***By learning how staff support the person in expressing their interests and beliefs*** ◊ ***By learning how staff support the person in expressing their individuality*** ◊ ***By learning how staff expose people to new things***
Personal Plans:	◆ ***By reading about things the person is involved in*** ◆ ***By determining whether the plan captures the "personality" and personal style of the person*** ◆ ***By determining whether the plan affords people opportunities to express their interests and beliefs*** ◆ ***By finding out about support strategies*** ◆ ***By determining whether plans and support strategies are individualized*** ◆ ***By reading reviews*** ◆ ***By seeing whether the plan is revised as needed***
Other Documentation:	◊ ***By reading logs*** ◊ ***By looking at calendars***
In the Community:	◆ ***By reading the local paper and looking at bulletin boards in the community to see whether their are opportunities for the person to express interests***

Outcome #9:	***People have control of their daily lives.***

What Do We See In People's Lives?

- ***Decision making***
- ***Information about alternatives***
- ***Awareness of consequences***
- ***Natural consequences***
- ***Personal responsibility***
- ***"House Rules" are the person's***
- ***Choices occur as a natural part of daily living***
- ***Decisions about how to spend money; priorities***
- ***Supported in carrying out choices***
- ***Decisions about with whom the person does things and where to do them***
- ***Decisions about daily living (room temperature, routines, etc.)***
- ***Hiring & firing staff***
- ***Evaluating staff performance***
- ***Individual "schedules"***
- ***Spontaneity, flexibility***
- ***Learning, personal growth***
- ***Developing self confidence & autonomy***
- ***Use of adaptive equipment to augment the person's ability to communicate choice or to control their environment***
- ***Carefully considering health and safety needs and looking for ways to support these needs with the least amount of intrusion while maximizing the person's control***
- ***When people need support in having things done for them, people are told before they are done and they are done with close attention to the person's responses (e.g., moving people from one place to another, medical procedures, changing clothing, etc.)***

Outcome #9: People have control of their daily lives.

What Do We See Staff Doing?

Knowing the Person Well:	◊ *Types of decisions the person has made in the past* ◊ *Types of decisions the person is comfortable making on their own* ◊ *Way the person wants support provided in making future decisions* ◊ *Understanding of the ramifications of those decisions* ◊ *Person's rituals and routines* ◊ *Person's comfort level with relating their decisions to others* ◊ *Understanding of consequences, responsibilities, and alternatives* ◊ *Understanding the person's sense of urgency about things* ◊ *Knowing how the person would like to be supported in hiring & firing staff and in evaluating their performance* ◊ *With whom the person wants to do things and where they want to do them* ◊ *Understanding the priorities people place on how money is spent* ◊ *Understanding how the person non-verbally indicates pleasure/displeasure, stop, like/dislike, etc.* ◊ *Knowing the person's health and safety needs*
Knowing the Choices the Person Faces:	◆ *Decisions the person will need to make* ◆ *Consequences of various decisions* ◆ *Possible alternatives* ◆ *Responsibilities associated with various choices* ◆ *Alternatives for addressing health and safety needs*
Bridging Between the Person & the Choices:	◊ *Listening to the person* ◊ *Double checking with the person* ◊ *Responding to the person* ◊ *Supporting the person in learning about alternatives & about possible consequences* ◊ *Supporting the person in hiring and firing staff and in evaluating performance* ◊ *Teaching or modeling decision making processes* ◊ *Facilitating learning from past decisions* ◊ *Looking for ways to support health and safety needs while maximizing personal control* ◊ *Supporting the persons in learning about financial management*

Outcome #9: People have control of their daily lives.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***By observing whom is making various decisions*** ◊ ***By observing the role people are in with relation to staff; whether staff work for the person*** ◊ ***By determining whether choice occurs as a natural part of daily living*** ◊ ***By observing the use of adaptive equipment to facilitate communicating choices or controlling the environment*** ◊ ***By observing staff's sensitivity to the person's non-verbal behavior when making decisions for people who do not overtly make their own choices*** ◊ ***By observing who decides things around the house (room temperature, schedules, routines)***
In People's Conversation:	♦ ***By talking with the person about who makes various decisions*** ♦ ***By talking with people about how decisions are made*** ♦ ***By talking with the person about consequences and responsibilities of various choices*** ♦ ***By talking with the person about what the house rules are and how "house rules" are established*** ♦ ***By talking with people about how staff are hired, fired and evaluated*** ♦ ***By hearing about who people want to do things with and how they want to do them***
From Staff:	◊ ***By talking with staff about how various things are decided*** ◊ ***Determining whether staff see choice as a part of daily life rather than something they allow, let, or give*** ◊ ***By talking with staff about the need to balance their responsibility to assure the person's safety with the person's need for autonomy and the rights of the person*** ◊ ***By talking with staff about the strategies they've used to increase the person's control*** ◊ ***By assessing staff's awareness of the gravity or seriousness of making any choice for the person*** ◊ ***By determining whether there is concerted effort toward assuring that the person has as much control as possible*** ◊ ***By talking with staff about preferences or issues related to the person's disability*** ◊ ***By learning about staff's awareness and understanding of the person's sense of urgency about things*** ◊ ***By finding out how the person is supported in hiring and firing staff and in evaluating staff performance*** ◊ ***By finding out about whether staff schedules are flexible to allow for adjustments to meet the person's schedule***

Outcome #9: People have control of their daily lives.

How Do We Determine If the Outcome Is Present? Chart Continued . . .

How Do We Determine If the Outcome Is Present?	
From Staff, Continued:	◊ ***By determining whether staff consider the person's sense of urgency about something with relation to how they (staff) prioritize it*** ◊ ***By asking about the use of adaptive equipment to communicate choice or to exercise control over the environment*** ◊ ***By asking whether there is a "Resident's Council" or "Resident's Rights" group and discussing the purpose and accomplishments of the group*** ◊ ***By talking about the hiring process, evaluation, and firing***
Personal Plans:	◆ ***Reading about strategies to increase the amount of control the person has*** ◆ ***By reading about the use of adaptive equipment to augment the person's ability to communicate choice or to control their own environment*** ◆ ***By reading reviews*** ◆ ***By seeing whether the plan is revised when needed***
Other Documentation:	◊ ***Reading schedules*** ◊ ***Reading logs*** ◊ ***Reading incident reports*** ◊ ***Reading house rules*** ◊ ***Reviewing admissions policies, hiring policies, and information about "Resident's Councils" or "Residents Rights" groups*** ◊ ***Reports on evaluation of satisfaction/dissatisfaction with agency supports*** ◊ ***Personnel file: Performance reviews*** ◊ ***Policies and procedures on hiring, firing, and performance review*** ◊ ***Policies on supporting people in selecting an agency***

Outcome #10	***People have the opportunity to advocate for themselves, for others and for causes they believe in.***

What Do We See In People's Lives?

- ***Assertiveness***
- ***Self-advocacy***
- ***Group advocacy***
- ***Free expression of opinions***
- ***No fear of recrimination***
- ***Equal relationships***
- ***Exercise influence***
- ***Participate on agency boards and committees***
- ***Participate on community and governmental boards***
- ***Fully exercise rights as a citizen***
- ***Proactively educated about rights as citizens***
- ***Have convictions, pursue causes***
- ***Have the opportunity for involvement in advocacy organizations or groups in the community***
- ***Have the opportunity to learn to speak for self and others through opportunities such as speaker's bureaus***

Outcome #10: People have the opportunity to advocate for themselves, for others, and for causes they believe in.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Assertiveness skills*** ◊ ***Values, beliefs, & interests*** ◊ ***Causes the person is interested in advocating for*** ◊ ***Issues the person feels strongly about in own life and in lives of others***
Knowing the Community Well:	◆ ***Groups or organizations locally which work for various causes*** ◆ ***Self-advocacy groups*** ◆ ***Assertiveness classes*** ◆ ***National organizations which offer opportunities to work for causes*** ◆ ***Opportunities within the agency*** ◆ ***Opportunities on the Internet***
Bridging Between the Person & the Community:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Responding to the person*** ◊ ***Coaching*** ◊ ***Teaching*** ◊ ***Connecting*** ◊ ***Supporting*** ◊ ***Involving*** ◊ ***Facilitating*** ◊ ***Transporting***

Outcome #10: People have the opportunity to advocate for themselves, for others, and for causes they believe in.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***By watching the person's interactions with staff and with others*** ◊ ***By observing whether change occurs in response to their assertiveness in a timely manner*** ◊ ***By observing staff's responses to people's suggestions***
In People's Conversation:	♦ ***By listening to the person talk about advocacy interests*** ♦ ***By hearing whether the person feels free to express opinions without worrying about recrimination*** ♦ ***By learning about the opportunities they have to influence agency policies and governmental policies*** ♦ ***Hearing about groups to which the person belongs***
From Staff:	◊ ***By hearing staff talk about how they support the person in advocating for themselves*** ◊ ***By hearing staff talk about how they support the person in advocating for causes*** ◊ ***By finding out about how people are involved in the operation of the agency*** ◊ ***By hearing the staff talk about groups to which the person belongs*** ◊ ***By finding out how staff support people in becoming involved with groups or causes*** ◊ ***By talking with staff about how they assure that they are not imposing their values on the person***
Personal Plans:	♦ ***By reading about strategies to support the person in becoming more assertive*** ♦ ***By reading about involvement in advocacy groups*** ♦ ***By reading strategies for involvement in the operation of the agency through the board, committees, etc.*** ♦ ***By reading reviews*** ♦ ***By seeing whether the plan is revised when needed***
Other Documentation:	◊ ***By looking at the constitution of the agency's board and committees*** ◊ ***By reading the agency's mission and goals***
In the Community:	♦ ***By learning about advocacy groups of various kinds in the community***

Outcome #11:	***People's plans reflect how they want to live their lives, the supports they want, and how they want them provided.***

What Do We See In People's Plans?

- ◊ ***Focus on the individual***
- ◊ ***Concentrate on building relationships***
- ◊ ***Result in concrete actions & outcomes***
- ◊ ***Involve problem solving, brainstorming solutions***
- ◊ ***Envision a desirable future***
- ◊ ***Include personal goals***
- ◊ ***Person knows what's in the plan***
- ◊ ***Person is actively involved throughout the process***
- ◊ ***Person has "ownership" of the plan***
- ◊ ***Reflects the person, is unique***
- ◊ ***Leaves you feeling you know the person***
- ◊ ***People who care about the person are involved throughout the process***
- ◊ ***Respectful***
- ◊ ***Support personal growth***
- ◊ ***Outline the supports needed to maintain the things that are working***
- ◊ ***Work toward the development of roles***
- ◊ ***Include functional goals & strategies***
- ◊ ***Include supports needed for health, safety, and behavioral reasons***
- ◊ ***Specify needed therapies***
- ◊ ***Specify any supports needed to fully exercise rights***
- ◊ ***Delineate any rights restrictions with assurance that the person has been afforded aggressive due process***
- ◊ ***Outlines what is important to the person and the overall plan may also include things that are important to others (e.g., safety issues)***
- ◊ ***Actively implemented in a timely manner***
- ◊ ***Outcomes are met***
- ◊ ***Commitment to change***
- ◊ ***Not a static document, changes as the person's situation changes***

Outcome #11: People's plans reflect how they want to live their lives, the supports they want and how they want them provided.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Personal goals & things they want to achieve*** ◊ ***Existing & potential capacities, interests, talents, & gifts*** ◊ ***Rituals to be supported*** ◊ ***Functional goals and strategies*** ◊ ***Physical, medical, behavioral supports*** ◊ ***Communication supports*** ◊ ***People care about (friendships, allies, family)*** ◊ ***Roles*** ◊ ***Ways the person might be comfortable in assuming more control of the meeting*** ◊ ***Places where the person is comfortable*** ◊ ***Rights issues*** ◊ ***Areas comfortable talking about*** ◊ ***Natural supports available to the person***
Knowing Planning & the Community:	♦ ***Opportunities in the community to address interests and personal goals*** ♦ ***Opportunities for roles*** ♦ ***Situations in which people can use their gifts, talents, and competencies*** ♦ ***Types of planning*** ♦ ***Ways the person can be in control***
Bridging Between the Person & the Community Through Effective Planning:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Responding to the person*** ◊ ***Facilitating*** ◊ ***Supporting*** ◊ ***Empowering*** ◊ ***Enhancing*** ◊ ***Advocating*** ◊ ***Changing*** ◊ ***Designing*** ◊ ***Developing***

Outcome #11: People's plans reflect how they want to live their lives, the supports they want and how they want them provided.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***Going to the meeting*** ◊ ***Watching the person carrying out goals*** ◊ ***Finding out what the person is learning*** ◊ ***Watching how the person is being supported*** ◊ ***Seeing whether the goals seem to make sense for the person in the context of their life and their community*** ◊ ***Observing what people seem to care about, where their interests lie*** ◊ ***Observing what supports are needed*** ◊ ***Actively pursuing the planning outcomes*** ◊ ***Chairing own planning meeting*** ◊ ***Pursuing new interests, talents, and gifts identified in the plan*** ◊ ***Efforts made to include the person on an ongoing basis throughout the process even after the meeting***
In People's Conversation:	◆ ***Talking with the person about their meeting*** ◆ ***Finding out who was at the meeting and how they were invited*** ◆ ***Finding out who was in charge of the meeting*** ◆ ***Learning what the person thought of the meeting and of the plan*** ◆ ***Asking how they feel about the goals, whether they are "theirs"*** ◆ ***Finding out if what's in the plan is important to the person*** ◆ ***Reading the plan with the person and talking about whether they go through it with staff*** ◆ ***Finding out whether the plan is being implemented*** ◆ ***Finding out what people care about*** ◆ ***Finding out who knows and cares about the person*** ◆ ***Finding out if the person is involved in monthly reviews***

Outcome #11: People's plans reflect how they want to live their lives, the supports they want and how they want them provided.

Where & How We Look For Evidence? Chart Continued . . .

How Do We Determine If the Outcome Is Present?

From Staff:	◊ ***Talking with staff about how decisions are made about who will come to the meeting, where it will be held, & when it will be held*** ◊ ***Talking with staff about what type of planning is used and why*** ◊ ***Asking staff about the process the agency uses*** ◊ ***Finding out whether staff know the plan*** ◊ ***Finding out whether direct support staff are involved in developing the plan and, if so, how*** ◊ ***Asking about issues around implementation*** ◊ ***Talking about the review process*** ◊ ***Finding out about what medical or physical supports the person needs*** ◊ ***Finding out what medications the person takes and why*** ◊ ***Finding out what responsibilities and timelines they have in supporting the person in meeting their outcomes***
Personal Plans:	◆ ***Reading the plan and any amendments*** ◆ ***Reading monthly reviews*** ◆ ***Reviewing any associated training plans, program plans, task analyses, etc.*** ◆ ***By determining whether the person has met any of the outcomes*** ◆ ***By looking at how progress is documented*** ◆ ***By seeing whether the plan is revised when needed***
Other Documentation:	◊ ***Read agency policies or procedures on planning*** ◊ ***Review any formats the agency uses*** ◊ ***Review training logs and any curriculum on planning*** ◊ ***Reviewing the person's medical information*** ◊ ***Reviewing incident reports*** ◊ ***Reviewing daily logs, program records, and progress notes***

Outcome #12:	People live and die with dignity.

What Do We See In People's Lives?

- ***Respected***
- ***Held in high regard, esteemed***
- ***Deference to the person***
- ***Interactions with the person show interest, concern, and consistency***
- ***Unconditional positive regard***
- ***Positive expectations***
- ***Worthwhile & important to others***
- ***Others feel they have benefited from knowing the person***
- ***Life is not wasted***
- ***Large blocks of time are not spent waiting or doing absolutely nothing***
- ***Death & grieving are handled respectfully***
- ***Making decisions about own funeral arrangements, burial, etc.***
- ***Opportunities to make decisions on how and where to die***
- ***Making funeral arrangements based on religious beliefs/faith***
- ***Chance to say 'good-bye' to family and friends***
- ***Attendance at funerals and memorials***
- ***Visiting grave site***
- ***Feelings are honored***
- ***Privacy needs are respected***
- ***People First language***
- ***Seen and described as a person rather than as a disability or label***
- ***Conversational tone***
- ***No differences between how staff and the person are treated***

Outcome #12: People live and die with dignity.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Knowing how the person wants to be supported*** ◊ ***Competencies, gifts, talents, and capacities*** ◊ ***Accomplishments, things the person can be proud of*** ◊ ***Feelings and preferences about death & dying*** ◊ ***Contributions the person has made*** ◊ ***Things that are bothersome or annoying to the person*** ◊ ***Recognizing what the person gives to others; how others benefit from knowing the person*** ◊ ***Knowing what the person's day is like; whether a great deal of time is wasted*** ◊ ***Knowing how the person wants to be supported in grieving for others and in dying***
Knowing the Community Well:	♦ ***Outlets in the community where the person's competencies, gifts, talents, and capacities might be honored*** ♦ ***Resources in the community such as grief counseling, hospice, etc.*** ♦ ***Places in the community where the person's contributions might be valued*** ♦ ***Holding positive expectations of the person***
Bridging Between the Person & the Community:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Responding to the person*** ◊ ***Modeling respectful interactions*** ◊ ***Introducing the person to others in dignified manner*** ◊ ***Using language which is respectful when conversing with or about the person*** ◊ ***Connecting*** ◊ ***Supporting*** ◊ ***Involving***

Outcome #12: People live and die with dignity.

How Do We Determine If the Outcome Is Present?	
In People's Lives:	◊ ***Watching interactions around major illness, dying, and grief*** ◊ ***Observing interactions between staff and the person and the person and others to see if they are respectful*** ◊ ***Observing whether the person has privacy for things others do in private*** ◊ ***Seeing whether there are differences in how staff and people are treated*** ◊ ***Seeing whether there are large blocks of time spent waiting or doing absolutely nothing*** ◊ ***Seeing how staff speak to and about the person*** ◊ ***Observing whether there are things the person cannot do that staff can do or parts of the house they cannot use that only staff can use*** ◊ ***Observing how staff comfort the person*** ◊ ***Opportunities for people to explore personal spirituality and faith***
In People's Conversation:	♦ ***Learning how people see themselves*** ♦ ***Learning people's vision of their future*** ♦ ***Hearing about what people are proud of*** ♦ ***Hearing about what people do, how much of their time is occupied in meaningful ways*** ♦ ***Hearing people talk about people they've known who've died or become critically ill*** ♦ ***Learning how much involvement the person has with others they care about***

Outcome #12: People live and die with dignity.

How Do We Determine If the Outcome Is Present? Chart Continued . . .

How Do We Determine If the Outcome Is Present?	
From Staff:	◊ ***Hearing language that is used to describe the person*** ◊ ***Hearing whether labels are used to describe the person or groups of people*** ◊ ***Asking about staff attitudes about the person and their capabilities*** ◊ ***Seeing whether staff honor the person's self vision*** ◊ ***Talking with staff about what the person has to be proud of*** ◊ ***Learning whether staff give the person unconditional positive regard*** ◊ ***Seeing whether interactions with the person show interest, concern and consistency*** ◊ ***Hearing how staff talk about the person*** ◊ ***Hearing about what happens during a typical week, whether time is occupied in meaningful ways*** ◊ ***Hearing about how staff provide support to people who are grieving, have major illnesses, or have died or are dying*** ◊ ***By talking with staff about how they feel they've benefited from knowing the person*** ◊ ***Hearing how staff support people who know someone who is critically ill or dying*** ◊ ***Finding out whether people supported by the agency who are dying or had a major illness remained at home and how support was provided*** ◊ ***Finding out about funerals and memorial services*** ◊ ***Asking about whether people ever visit the gravesite of friends or family members who have died*** ◊ ***Finding out whether people have a chance to say good bye to family and friends*** ◊ ***By finding out if there are people the agency supports who have died and how funeral arrangements were made*** ◊ ***By finding out whether the agency offers any training on death and dying*** ◊ ***By finding out whether staff make adjustments to the person's needs when the person is grieving***

Outcome #12: People live and die with dignity.

How Do We Determine If the Outcome Is Present? Chart Continued . . .

How Do We Determine If the Outcome Is Present?	
Personal Plans:	♦ ***Finding out whether plans include respectful descriptions of the person*** ♦ ***Seeing whether plans describe a full life rather than one filled with large blocks of time spent waiting or doing absolutely nothing*** ♦ ***Reading plans to see if the interventions and training included in the plan are respectful of the person, honor their need for dignity*** ♦ ***By finding out whether plans deal constructively and respectfully with issues around death, dying, and grief*** ♦ ***By reviewing plans*** ♦ ***By seeing whether plans are revised when needed***
Other Documentation:	◊ ***Reading logs and incident reports*** ◊ ***Reading the agency's mission statement and brochures*** ◊ ***Reviewing materials used for fund raising and public relations*** ◊ ***By reading about burial arrangements***

Outcome #13:	***People feel safe and experience emotional well-being.***

What Do We See In People's Lives?

- ***Stability***
- ***Consistency***
- ***Assured, safeguarded***
- ***Neighborhood feels comfortable or secure to the person***
- ***Safe housing***
- ***Possessions are safe from theft by others***
- ***Harmonious living & working environments***
- ***Feeling comfortable and at home***
- ***Having a safe place and way to vent feelings of anger or frustration***
- ***Having someone to talk to besides staff***
- ***Supported emotionally***
- ***Being comforted***
- ***Preparation for change***
- ***Counseling***
- ***Opportunities to express feelings through creative efforts***
- ***Opportunities to express thoughts and feelings through writing (journal, diary, etc.)***
- ***Spirituality***
- ***Opportunities to learn relaxation techniques***

Outcome #13: People feel safe and experience emotional well-being.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Things that make the person feel safe*** ◊ ***Areas where consistency is important*** ◊ ***What it takes for the person to trust someone or to feel secure in a situation*** ◊ ***Things the person sees as comforting*** ◊ ***Amount of preparation needed for change*** ◊ ***Ways the person likes to deal with stress or other emotional health issues*** ◊ ***Ways that are safe and comfortable to express feelings***
Knowing the Community Well:	♦ ***Places in the community where the person would feel safe*** ♦ ***People the person trusts*** ♦ ***Places the person could go to learn to deal with stress or other emotional health issues (e.g., counseling, relaxation exercises, etc.)***
Bridging Between the Person & the Community:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Responding to the person*** ◊ ***Supporting*** ◊ ***Connecting*** ◊ ***Comforting*** ◊ ***Preparing***

Outcome #13: People feel safe and experience emotional well-being.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***Observing people's comfort levels in different situations at different places*** ◊ ***Observing whether the person appears to feel safe in their neighborhood and in their home***
In People's Conversation:	♦ ***Talking with the person about whether they feel safe*** ♦ ***Hearing what people do when they feel sad, upset, etc.*** ♦ ***Hearing people talk about possessions that are missing or have been stolen*** ♦ ***Finding out whether the person keeps a diary or journal***
From Staff:	◊ ***Talking with staff about what seems to help the person feel secure and how they support the person in feeling safe*** ◊ ***Talking with staff about how they let the person know about changes in schedule, daily routine, etc.*** ◊ ***Talking with staff about how they support the person in finding strategies that help them deal with stress or other emotional health issues*** ◊ ***Talking with staff about how they support the person in keeping their possessions safe***
Personal Plans:	♦ ***Reading recommendations for counseling, relaxation therapy, etc.*** ♦ ***Reading strategies to support the person in feeling safe*** ♦ ***Reading strategies to support the person's need for notification of change*** ♦ ***Reading reviews*** ♦ ***Seeing whether plans are revised when needed***
Other Documentation:	◊ ***Looking at the person's history for a pattern of stability in their life***
In the Community:	♦ ***Driving around the community to look for resources for emotional well being*** ♦ ***Looking in the phone book***

Outcome #14:	***People are supported to attain physical wellness.***

What Do We See In People's Lives?
◊ ***Exercise*** ◊ ***Athletics*** ◊ ***Diet*** ◊ ***Learning about good nutrition*** ◊ ***Learning about and having healthy snacks*** ◊ ***Taking time off to relax*** ◊ ***Learning to make own doctor's appointments*** ◊ ***Learning First Aid, CPR*** ◊ ***Learning to take own medications*** ◊ ***Understanding own health care issues*** ◊ ***Planning for doctor's appointments*** ◊ ***Groups that deal with specific health issues*** ◊ ***Health club membership*** ◊ ***Fitness equipment and/or accessories*** ◊ ***Fitness routine and schedule is determined by the person***

Outcome #14: People are supported to attain physical wellness.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Health status*** ◊ ***Exercise preferences*** ◊ ***Interest in athletics*** ◊ ***Foods the person likes*** ◊ ***Capabilities with regard to first aid and CPR*** ◊ ***Support wanted or needed in dealing with medical care appointments, communication with medical professionals and overall health issues*** ◊ ***Relationship with health care professionals***
Knowing the Community Well:	◆ ***Places where people get exercise in different ways*** ◆ ***Diet centers, first aid & CPR classes*** ◆ ***Groups related to specific diseases (diabetes, heart disease, cancer, etc.)*** ◆ ***Healthy cooking classes*** ◆ ***Wellness learning center***
Bridging Between the Person & the Community:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Responding to the person*** ◊ ***Connecting*** ◊ ***Supporting*** ◊ ***Modeling*** ◊ ***Encouraging*** ◊ ***Educating*** ◊ ***Teaching*** ◊ ***Advocating***

Outcome #14: People are supported to attain physical wellness.

How Do We Determine If the Outcome Is Present?	
In People's Lives:	◊ ***By going with people when they do things in the community (Aerobics class, Weight Watchers, etc.)*** ◊ ***By observing meal preparation*** ◊ ***By observing whether there are opportunities for exercise*** ◊ ***By observing people's food choices***
In People's Conversation:	♦ ***By talking with people about their relationship with and feelings about their doctor*** ♦ ***By talking with people about their overall health status*** ♦ ***By talking with people about various exercise interests*** ♦ ***By talking with people about their lifestyle*** ♦ ***By talking about diet, nutritional needs, and interests***
From Staff:	◊ ***By asking about the person's health status*** ◊ ***By asking about how they support the person in preparing for doctor's appointments*** ◊ ***By asking about opportunities people have to learn about and handle their own health care needs*** ◊ ***By asking about who is on special diets and why*** ◊ ***By talking about people's opportunities for exercise and preferences in this area*** ◊ ***By asking about how people are supported in building a healthy lifestyle*** ◊ ***By asking how people are supported in dieting and exercise***
Personal Plans:	♦ ***By looking for personal goals around diet or exercise*** ♦ ***By looking for goals related to handling own health care needs*** ♦ ***By reading reviews*** ♦ ***By seeing whether plans are revised when needed***
Other Documentation:	◊ ***By reading doctor's orders and physicals***
In the Community:	♦ ***By driving around and looking for parks, YMCAs, health clubs or other places to exercise*** ♦ ***By looking in the phone book for diet centers*** ♦ ***By reading the paper and local bulletin board for cooking classes, disease groups, exercise opportunities, etc.***

Outcome #15:	

	People are actively supported throughout the process of making major lifestyle changes.

What Do We See In People's Lives?
◊ ***Deciding who provides the supports*** ◊ ***Deciding who to live with*** ◊ ***Deciding where to live*** ◊ ***Deciding when to move*** ◊ ***Deciding whether to stay in school*** ◊ ***Deciding where to work*** ◊ ***Making major life choices about relationships*** ◊ ***Planning for transitions*** ◊ ***Planning a meaningful retirement*** ◊ ***Having relevant information about major decisions***

Outcome #15: People are actively supported throughout the process of making major lifestyle changes.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***Whether the person wants to live or work somewhere else*** ◊ ***Whether circumstances may force the person to move or to work elsewhere*** ◊ ***Whether the person wants to marry, have children, divorce*** ◊ ***Desire to retire*** ◊ ***Leave school and start work*** ◊ ***Who the person wants to live with*** ◊ ***Lifestyle preferences***
Knowing the Community Well:	◆ ***Housing options*** ◆ ***Job opportunities*** ◆ ***Counseling for various transitions*** ◆ ***Parenting classes*** ◆ ***Retirement groups or organizations*** ◆ ***Employment counseling***
Bridging Between the Person & the Community:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Responding to the person*** ◊ ***Connecting*** ◊ ***Supporting*** ◊ ***Advocating***

Outcome #15: People are actively supported throughout the process of making major lifestyle changes.

How Do We Determine If the Outcome Is Present?	
In People's Lives:	◊ ***Observing whether there are any imminent transitions*** ◊ ***Observing staff interactions with the person about major lifestyle changes***
In People's Conversation:	♦ ***Talking with the person about whether they like where they live and work*** ♦ ***Talking with the person about where they lived and worked before and how the decision to make a change was made*** ♦ ***Talking with the person about whether they are planning to move, change jobs, retire, etc.*** ♦ ***Talking with people who are planning to marry or have children or divorce about how they are being supported in making and carrying out these decisions*** ♦ ***Finding out with whom the person wants to live or share a room*** ♦ ***Talking with the person about who and how supports would be provided***
From Staff:	◊ ***Talking with staff about how decisions are made about moving, changing jobs, or retiring*** ◊ ***Learning how staff support the person in carrying out major life style changes involving moving, changing jobs, or retiring*** ◊ ***Talking with staff about how they support people who express an interest in marrying or having children*** ◊ ***Learning how decisions are made about who lives together and who shares rooms*** ◊ ***Talking with staff about how decisions about who will support the person are made***

Outcome #15: People are actively supported throughout the process of making major lifestyle changes.

How Do We Determine If the Outcome Is Present? Chart Continued . . .

How Do We Determine If the Outcome Is Present?	
Personal Plans:	♦ ***Looking for strategies to support various transitions*** ♦ ***Looking for concrete action steps that will help the person reach their own goals about where to live or work*** ♦ ***Looking for goals which address the person's desire to marry or have children and for strategies which will assist them in fully understanding the responsibilities associated with these decisions and enable them to carry out responsible decisions*** ♦ ***Looking for goals and strategies which support the person in having a meaningful retirement*** ♦ ***Looking for reasonable timelines for completion*** ♦ ***Reading reviews*** ♦ ***Seeing whether plans are revised when needed***
Other Documentation:	◊ ***Reading the agency's admissions and discharge policies*** ◊ ***Reading logs for actions already completed toward the change***
In the Community:	♦ ***Looking in the phone book for places where the person might find support for major transitions*** ♦ ***Observe within the community***

Outcome #16:	***People are supported in managing their home.***

What Do We See In People's Lives?

- ***Preparing meals***
- ***Cleaning***
- ***Laundry***
- ***Home repairs***
- ***Decorating***
- ***Sewing, mending***
- ***Carpentry***
- ***Caring for the lawn & garden***
- ***Banking, paying bills***
- ***Shopping***
- ***Budgeting***
- ***Prioritizing***
- ***Problem solving***
- ***Locating/purchasing needed community services***
- ***Handling phone solicitation, obscene callers***
- ***Doing household tasks with enough frequency to learn them***
- ***Being involved in the whole process from beginning to end; functional chain (making the list, going to the store, paying for the groceries, putting the groceries away)***
- ***Staying safe (changing smoke detector batteries, strangers at the door)***

Outcome #16: People are supported in managing their home.

What Do We See Staff Doing?	
Knowing the Person Well:	◊ ***How they want to live their life*** ◊ ***Current abilities & abilities needed to live desired lifestyle*** ◊ ***Interests in various things related to home management*** ◊ ***Preferences in how support provided*** ◊ ***How the person likes to learn*** ◊ ***What supports the person needs to live desired lifestyle***
Knowing their Home & the Community Well:	◆ ***Locations in the community to learn various skills (e.g., cooking classes)*** ◆ ***Alternatives available in the community (places which could perform various tasks for the person)*** ◆ ***How to do the things that need to be done*** ◆ ***Planning for the needed frequency to establish the skill*** ◆ ***Teaching methods that might be helpful***
Bridging Between the Person, their Home & the Community:	◊ ***Listening to the person*** ◊ ***Double checking with the person*** ◊ ***Responding to the person*** ◊ ***Exploring*** ◊ ***Enrolling*** ◊ ***Task Analyzing*** ◊ ***Teaching*** ◊ ***Supporting*** ◊ ***Adapting*** ◊ ***Connecting*** ◊ ***Modeling*** ◊ ***Housing options and funding***

Outcome #16: People are supported in managing their home.

How Do We Determine If the Outcome Is Present?

In People's Lives:	◊ ***Observing what things people do for themselves*** ◊ ***Observing how other things get done***
In People's Conversation:	♦ ***Talking with people about their interest in various things related to home management*** ♦ ***Talking with people about how they like to be supported in learning*** ♦ ***Finding out whether people pay their bills & how they access their money***
From Staff:	◊ ***Talking with staff about how decisions are made about what people will learn*** ◊ ***Talking with staff about how support is provided*** ◊ ***Talking with staff about alternatives that are available in the community*** ◊ ***Asking about who is responsible for doing different things and about how this is decided*** ◊ ***Asking about frequency of opportunities to do various things*** ◊ ***Asking about shopping, decorating, and home repair*** ◊ ***Asking about who handles banking and paying bills*** ◊ ***Learning how staff select teaching methods*** ◊ ***Talking with staff about how they plan for the frequency needed to establish the skill***
Personal Plans	♦ ***Looking for goals about home management which fit with the person's preferences and lifestyle*** ♦ ***Reading about how support is provided*** ♦ ***Hearing about what teaching methods are used*** ♦ ***Determining the frequency with which skills are used*** ♦ ***Reading reviews*** ♦ ***Seeing whether plans are revised when needed***
Other Documentation:	◊ ***Reading logs*** ◊ ***Reading policies about how to access money that belongs to the person***
In the Community:	♦ ***Looking at bulletin boards in local restaurants and businesses*** ♦ ***Checking the local paper*** ♦ ***Looking in the phone book***

Outcome #17	***Action at all levels of the organization is consistent with a shared mission which is developed in response to the goals and aspirations of the people supported.***

What Do We See In People's Lives?

- ***Clear progress toward goals***
- ***Goals that are meaningful to the person***
- ***Purposeful action rather than random activities***

What Do We See Staff Doing?

- ***Staff throughout the organization have a shared mission***
- ***Staff actions are consistent with their shared sense of purpose***
- ***Staff know why they are doing the things they are doing***
- ***Both the shared purpose and the actions are consistent with the goals and aspirations of the people supported by the agency***

Outcome #17:	***Action at all levels of the organization is consistent with a shared mission which is developed in response to the goals and aspirations of the people supported.***

How Do We Determine If the Outcome Is Present?

- ◊ ***Ask to see any written materials the agency may have which defines it's purpose***
- ◊ ***Ask staff at different levels of the organization what the agency's purpose is***
- ◊ ***Ask the people supported by the agency what the agency's purpose is***
- ◊ ***Determine whether the actions fit with the stated, shared purpose***
- ◊ ***Determine involvement of the person in the development of agency mission and goals***

Outcome # 18	***The agency initiates and maintains positive working relationships with other organizations within and outside the service delivery system.***

What Do We See In People's Lives?

- ***The person receives needed supports***
- ***The person benefits from the agency's ties to others in the service delivery system***
- ***The person benefits from the agency's ties to others in the community***

What Do We See Staff Doing?

- ***Staff proactively work with other organizations***
- ***Staff are actively involved in the community***
- ***There are harmonious working relationships with others***

Outcome #18: ***The agency initiates and maintains positive working relationships with other organizations within and outside the service delivery system.***

How Do We Determine If the Outcome Is Present?

- ***Ask about working relationships with other organizations***
- ***Determine, from all other evidence, whether the agency's relationships facilitate or stand in the way of the person receiving needed supports***
- ***If there are problem areas, determine how the agency is working with others to meet the person's needs***

Outcome #19	*The agency empowers staff to meet people's needs.*

What Do We See In People's Lives?

- ***People's needs are met***
- ***People spend less time waiting to have needs met***

What Do We See Staff Doing?

- ***Direct support staff have and use the authority to meet people's everyday needs***
- ***Direct support staff generally act promptly in response to the person's needs rather than waiting for permission***
- ***Staff assume it is their job to meet the person's needs***
- ***Problems are solved at the lowest level possible***
- ***Administration fosters creativity and responsible risk taking at all levels of the organization***
- ***Organizational structure tends to be flatter, less hierarchical***

Outcome #19: The agency empowers staff to meet people's needs.

How Do We Determine If the Outcome Is Present?

- ***Determine what causes delays in meeting the person's needs***
- ***Determine where action toward the person's goals breaks down***
- ***Look for the causal pattern from trends identified through other ratings***

Outcome #20	***The agency regularly evaluates its success in meeting people's needs.***

What Do We See In People's Lives?

- ◊ ***Attention is being paid to whether or not people's personal goals are met***
- ◊ ***People's needs are met***
- ◊ ***People feel listened to***
- ◊ ***People feel comfortable sharing their needs with staff***
- ◊ ***Regular changes are made to ensure goals are met***
- ◊ ***Regular reviews are made to determine if goals are being met***

What Do We See Staff Doing?

- ◊ ***Staff listen closely to what people are saying***
- ◊ ***Staff make changes that are needed to better respond to people***
- ◊ ***There are formal and informal means to gather information about whether the agency is responding to people***

Outcome #20:

The agency regularly evaluates its success in meeting people's needs.

How Do We Determine If the Outcome Is Present?

- ◊ ***Ask how the agency formally and informally learns what people want and how they determine whether these needs are met***
- ◊ ***Ask about program evaluation, quality assurance, and/or consumer satisfaction activities***
- ◊ ***Determine what structures/processes the agency has in place to act on discrepancies between what people need and how the agency is doing in meeting those needs***
- ◊ ***Enhancement plans and other strategic plans***

Person Centered Planning Guidelines

Revised and Approved January 2005

Table of Contents

Section I - Overview of Person Centered Planning

INTRODUCTION:

The Division of Mental Retardation and Developmental Disabilities requires that each person eligible for Division services have a person centered plan. These guidelines are to be used by self advocates and their families, regional centers and provider agencies, who facilitate and write plans with all persons receiving supports and services from the Division.

The Centers for Medicare and Medicaid Services (CMS previously known as HCFA), also defines and adopts the person-centered process and the values as a means of providing supports and services to individuals (CMS Home and Community Based Services Quality Framework, May, 2003). CMS provides this definition:

"Person-centered planning is a process directed by the individual, with assistance as needed from a representative. It is intended to identify strengths, capacities, preferences, needs and desired outcomes of the participant. The process may include other individuals freely chosen by the participant who are able to serve as important contributors to the process. The person-centered planning process enables and assists the individual to access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve ***personally defined outcomes*** *and the training, supports, therapies, treatments and/or other services, become part of the person-centered plan".*

The CMS outcome for what they call "participant-centered service planning and delivery" states:

Desired outcome:
"Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community".

This outcome includes:

- *Assessment (Comprehensive information concerning each participant's preferences, personal needs, goals and abilities, health status and other available supports gathered and used in developing the personalized plan).*

- *Decision Making (Information and support available to help the participant to make informed selections among service options).*

- *Free Choice of Provider (to assist participant to freely choose among qualified providers).*

- *Plan is comprehensive (Addresses the participant's need for services, healthcare or other services in accordance with his/her expressed preferences and goals).*

- *Person-directed (Participant has the authority and are supported to direct and manage their own services to the extent they wish).*

CMS administered Home and Community Based Waivers, require that each person initially have a plan in place within 30 days of acceptance into the program. If the person already has a person centered plan, then the plan must be amended within 60 days to reflect what new services and supports will be provided to the person upon entrance into the waiver.

PERSON CENTERED VALUES

All plans should be in accordance with the DMRDD's Quality Outcomes. There are certain basic beliefs that form the foundation of the Outcomes and these should be considered throughout planning. These are the belief that:

- **People with disabilities, their families and friends are the experts in defining what is important in their lives. It is important that we listen to and respect their expertise.**
- **People can express what is important to them if you pay attention and listen. It is important to provide a variety of ways for people to express their needs and wants.**
- **Things that are important to most community members (e.g., relationships, a sense of security, belonging, etc.) are also the things that are important to people with disabilities. This "typical community life" should be the yardstick that is used to guide us in developing supports for people with disabilities.**
- **Partnership and communication between the person supported, regional center and provider staff, family, friends and community members is important.**
- **Both the person supported and those providing support can grow through continuous learning. Continuous learning and growth should always be supported and encouraged.**
- **When learning or doing something new, there is usually risk involved. Growth does not occur without risk and continuous learning and growth should always be supported.**
- **Certain aspects of life (health, safety and legal rights) are essential to all people.**
- **Person centered plans should create change for and with the person being supported.**
- **Plans should always show the desired future of the individual and should result in real action taking place.**
- **When the individual desires or is experiencing a significant life change, such as obtaining employment, retirement, transitioning from school to adulthood, transitioning out of an institution to the community, transitioning from a hospital back home and planning for end of life, the planning process should be used to determine what needs to occur to safely make the change happen.**
- **Privacy needs must be respected.**

PLANNING FOR TRANSITION

Plans focusing on life transitions should include information about:

- **The person's desired or needed outcomes based upon information found in the profile.**
- **What steps or supports the person will need to achieve the outcomes.**
- **How the person's gifts, interests and talents will continue to be recognized and supported during the transition/life change;**
- **What works/doesn't work for the person to help develop strategies for support in the new situation;**
- **How the person's needs will be met, including medication, behavioral, safety and health care needs.**
- **Relationships that need to be maintained.**
- **History that should not be lost, especially related to family, behavioral supports, health and safety.**
- **How personal connections of those present at the planning meeting might be accessed to help the person succeed.**

For example, for persons seeking employment, the plan should be used as a tool to:

- **Provide a description of the person's gifts, interests and talents which can be used when developing a resume, employment portfolio or career plan;**
- **Provide a description of what needs to happen for the person to successfully attain employment;**
- **Use What Works/Doesn't Work to describe how to best support the person on the job; and**
- **Describe how persons present at the planning meeting will continue to support the person, i.e., developing a list of potential employers, transporting to job interviews, teaching interviewing skills, using personal connections to get interviews etc.**

PLANNING FOR RISK

When the person will be learning or doing something that involves increased risk, the plan or action plan should describe:

- **Efforts that have been made to assure the person is making an informed choice. What has been done to assure that the person clearly understands what risks are involved and possible consequences of their actions?**
- **What the person needs to know and the skills and supports that are necessary for the person to achieve their goal;**
- **How supports will be provided, skills that will be taught and by whom;**

- **What others in the community need to know and do to provide support to the individual;**
- **What follow-up and monitoring will occur.**

INITIAL PLANS

Initial plans must contain at least an accurate beginning profile of the person. The profile needs to reflect what the person sees as important in:

- **Relationships,**
- **Things to do,**
- **Places to be, and**
- **Rituals and routines. Rituals and routines are especially important when the person needs a high level of support in getting things done and cannot tell people how s/he wants them done.**
- **The plan must also contain a description of immediate needs, especially those that relate to things that are important to the person's quality of life including health and safety.**
- **Information about what supports and/or services are required to meet the person's needs.**

The plan facilitator must make sure that each item in the action plan has enough detail and/or examples so that someone new in the person's life understands what is meant and how to support the person.

The initial plan can cover no more than 60 days, during which time a more comprehensive plan must be finalized. This more comprehensive plan will need to meet the criteria set forth in the remainder of this document.

PLAN COMPONENTS

Plans should have three main components:

- **<u>The Personal Profile</u> describes how the person wants to live, his/her routines, what s/he wants to learn and how s/he learns best. There will be multiple sections in the profile. For example: What and who are important to the person must be included. It should describe what interferes with what the person wants as well as the ways wants and needs may be met. The profile should also describe the person's preferences regarding how supports are delivered and who will provide them (what works or does not work in supporting the person). The profile will include a demographics section and a list of contributors. Contributors are those who have provided information in the development of the plan. It includes, at a minimum, the individual, his guardian, and the service coordinator. It may also include anyone the person supported wants involved: family, friends, co-workers, direct support staff, etc.** The plan facilitator should make sure that the person

supported understands that s/he may invite anyone s/he wants to contribute to the plan.

- **<u>The Action Plan</u> describes what the person would like to accomplish, learn or change and specifically how these outcomes will be achieved. It is crucial that the action plan reflects what priorities the person has identified as important. There should be a direct link between the information gathered in the profile and the action plan.**

  Before actual outcomes and action steps are written, the planner should complete a section called: What needs to be Maintained/Enhanced? What needs to be Changed/Different? **This is an analysis that sets the agenda for what needs to be preserved and what needs to be changed. This part of the action plan connects what is important to the person to the outcomes and action steps being developed.**

  The descriptions of what needs to be maintained are things that make sense in the person's life that are currently happening and need to continue to happen, with the assistance of members of the person's circle of support. This information might include relationships that need to continue, the person being able to work at a job he enjoys and rituals that are being respected.

  What needs to be changed should focus on: a) things that are important to the person but are not present; and b) things that are present, but that make the person unhappy. This might include the person not liking a job, not getting to spend time with family or having to live with someone he does not get along with.

  The plan facilitator should present the information so that it is clear whose perspective is being represented, the person, family member, friend, direct support staff, guardian etc. There are times, for instance, that a guardian may feel something needs to occur that is not a priority for the person.

  If the person expresses a need, the action plan should address this need. If there is a barrier to meeting the need, then the plan should describe the barriers and offer possible solutions and timetables for overcoming them.

  The action plan must include specific steps for each outcome as well as persons responsible for providing support and timelines for accomplishment. Those providing support should have access to the plan and use it as a guide for what activities need to be done with and/or on behalf of the person. Therefore, information regarding what is expected of staff should be very clear.

- **<u>Legal Issues</u> include information about legal status; restrictions placed by the court system and dated signatures of the person, his legal guardian (if appropriate) and the service coordinator.**

UPDATING PLANS

In the past, plans were developed at an annual meeting and rarely changed from year to year to reflect how the person, their goals and desires have changed. Person centered plans are expected to change and develop over time as service coordinators and others get to know the person well, spending time with him in a variety of situations and environments. We need well written plans, but the <u>process</u> of planning with the person is even more important than the document it produces because the process empowers the individual. Reviews/updates need to occur through discussion/dialogue with the person and their circle of support, not just a review of the person centered plan. Plans must be reviewed (and updated if necessary) on <u>at least</u> a quarterly basis. However, review and update of the plan must also occur when:

- **The person or the person's guardian requests that information be changed or added;**
- **Others invited by the person to participate in his plan provide additional information; or**
- **The need for supports and services change. For instance, the person's level of functioning may change requiring either a reduction or increase in services. A new assessment revels additional support or service needs. The person's natural support system may expand, reducing the need for a paid service, or staff discovers another agency that will provide additional resources to the person.**

When you update or otherwise change a plan, it is important that the person or his/her guardian is aware of and approves any changes made. Documenting this approval generally requires the signature of the person or guardian, but for certain types of changes and within a specific framework, there is an alternative. There are two ways to make changes to a plan. You may a) write an addendum to the plan (which requires a dated signature of the person and their guardian) or b) you may state within the plan circumstances under which information may be added without obtaining another signature.

Occasionally, a guardian may indicate that no changes may be made to a plan without prior approval. In this case, changes will need to be described in an addendum. The addendum will need to be signed and dated by the guardian prior to implementation.

Significant changes always require dated signatures. The way to include significant changes to a plan is by writing an addendum to the plan. The following types of changes are considered significant and require an addendum that includes a rationale for changes made:

- **Adding or Changing an Outcome**
- **Adding or changing a service. (e.g. Someone begins receiving respite, someone moves from a group home or ISL);**
- **Proposing to restrict someone's rights; or**
- **Taking any other type of adverse action (e.g. canceling a service, termination from the waiver).**

Informational changes do not require signatures. Changes that are primarily informational may be documented on a "working plan", in reviews or through other tools rather than through an addendum. The plan may describe circumstances under which such information may be added without obtaining new signatures. Types of changes, which may be made in this way, are:

- **The additional information provides clarity to a section on the plan. (e.g. the plan states the person does not like sports, but it is discovered that he likes swimming);**
- **More detail is added to a plan that does not require a change in the outcome (e.g. The outcome states the person enjoys and wants to go to movies but later it is discovered that he does not like romantic comedies); or-**
- **The action step or strategy is not working for the person, but the outcome remains the same. Action steps and strategies for obtaining the outcome may change without an addendum being completed as long as it does not result in a change in services and supports.**

<u>In these situations, the outcome must have an action step that describes how staff would document and share what they have learned with the rest of the support team</u>.

For example:

Outcome: John will become more familiar with recreational activities in his community.

Rationale: John just moved to this area. He enjoys swimming, walking and reading. He wants to learn what is available and decide which activities to pursue.

Action Step:

Staff from the ABC Center will assist John in accessing community resources for swimming, reading and walking three times a week. Monthly notes will document John's reaction to the activity and whether:

- **John wishes to attend similar events in the future,**
- **John wishes to join a class, club or organization**
- **John wishes to pursue other interests.**

Direct support staff may share information about the person in a variety of ways such as sharing progress notes, at monthly meetings, providing a "working plan" to support staff on which to write insights, etc. The person, his/her service coordinator or plan facilitator must decide how to incorporate the information into the plan and make sure it is done. The plan facilitator must ensure the accuracy of information provided, which may be done by asking the person, observing behavior, or checking with those who know and care about the person.

PLANS AND OTHER WAIVER DOCUMENTATION

Section 13.9 A of the waiver manual contains information regarding documentation requirements for persons receiving waiver services. It states that

"**Implementation of services *must* be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive residential habilitation or individualized supported living and at least quarterly for individuals who live in their natural home. The provider is required to document the provision of MRDD Waiver services by maintaining:**

- attendance or census records documenting days of service signed by the provider or designated staff;
- daily activity records that describe various covered activities (services) in which each person participated;
- records of which staff provided each unit of service;
- documentation that each such staff is qualified to provide the service;
- progress notes by direct care staff regarding situations or incidents (good or bad) that arise affecting the individual, and;
- monthly summaries that describe progress on the individual's person centered plan goals and objectives and overall status of the individual.

All providers must follow the above documentation requirements unless otherwise noted under specific MRDD Waiver services in Sections 13.16 through 13.33 of the waiver manual. Non-waiver service providers are expected to have similar documentation. The service coordinator is responsible for ensuring that waiver documentation requirements are met.

Information in the plan, reviews, monthly reports etc. also needs to be consistent with and not contradict information in other waiver documentation. Before entering the waiver, a service coordinator determines eligibility for the waiver by completing the Evaluation of Need for an ICF/MR Level of Care Form (ICF/MR or LOC form). (See Appendix A, pg 22) This form documents the person's eligible diagnoses and that without the waiver; the person would require active treatment in an ICF/MR. When developing the plan, service coordinators must consider the seven (7) functional areas identified on the form where the individual requires supports and document in the plan how these supports will be provided.

For individuals who are residing in an ICF/MR and who are transitioning to the community, plans will need to reflect that habilitation professionals are working to transition the individual to community services; however an ICF/MR level of care continues to be needed. The plan must describe how these needs will continue to be met in the ICF/MR until the person actually moves to the community. The plan must also describe how the needs will be met in the community after the person moves from the institution.

The ICF/MR form takes its cue from the MOCABI and other functional assessments. **Presumably, any "significant functional limitation" on these assessments would represent an issue for the person. A limitation would be considered an issue if supports or services are needed for it or if staff need to know or do something to ensure something happens (or continues to happen) for a person.**

The seven (7) functional areas from the ICF/MR Level of Care form are listed below.

- Medical
- Behavioral
- Communication
- Cognitive Abilities
- Daily Living Skills
- Motor Development
- Socialization

The person-centered plan needs to contain clear information reflecting each functional limitation noted on the LOC form, with the exception that cognitive abilities will not always have a specific action or support associated with it. Limitations in cognitive abilities tend to cause or compound limitations in other areas and the plan overall should identify what is being done to meet the person's needs in those areas.

How the limitations in the level of care form are reflected in the person centered plan will vary significantly. Goals or objectives are NOT necessary for each indicated limitation; however, if the limitation presents an issue for the person, the plan must communicate what is to be done about it i.e. what services and supports will be provided.

SERVICE COORDINATOR RESPONSIBILITIES

There will be times when the person, family member, guardian, the provider or someone else of the person's choosing, will want to direct the person centered plan. This is perfectly acceptable. When this occurs, the service coordinator is still responsible for the following:

- **Ensuring eligibility for the waiver through the use of appropriate assessment tools (MOCABI, Level of Care Determination form, Vineland, etc).**
- **Ensuring that waiver documentation requirements are met.**
- **Reviewing other assessments that have been conducted (health, behavioral, risk etc) prior to developing or updating a plan and ensuring that recommendations regarding additional support or service needs are addressed in the plan.**
- **Knowing when plans are due and assuring that planning meetings are conducted in a timely fashion.**
- **Making sure plans are dated and signed at least annually by the person, his guardian and the service coordinator.**
- **Making sure addendums are dated and signed by the person, their guardian and service coordinator.**
- **Reviewing the plan to make sure the guidelines described in the remainder of this document are met.**
- **Supporting the person and whoever is writing the plan in understanding the guidelines described in the remainder of this document.**
- **Ensuring that the guardian, support staff and the person have copies of the plan.**

The material that follows was created to assist service coordinators in developing plans that meet both person centered planning and waiver criteria. In instances where someone else writes the plan, the service coordinator continues to be responsible for ensuring these criteria are met. Service coordinators should use the material under the Person Centered Planning Guidelines for reviewing plans written by others.

PROVIDER RESPONSIBILITIES

When the provider facilitates the development of the person centered plan, the service coordinator will work with the agency to ensure that the plan meets guideline criteria. Providers working with an individual are also responsible for:

- **Informing the service coordinator / guardian of any issues that arise while implementing the plan, including the inability of the provider to provide supports or services prescribed in the plan;**
- **Informing the service coordinator / guardian of any need for changes to the plan; and**
- **Documenting the provision of supports and services according to Sections 13.9 a / b and 13.16 – 13.33 of the Medicaid Waiver Manual.**

When a provider facilitates the development of the person centered plan, the service coordinator responsibilities listed in the previous section, do not change.

PROVIDER QMRP RESPONSIBILITIES:

Whether the provider facilitates the plan or participates in its development as a member of the interdisciplinary team, the provider Qualified Mental Retardation Professional (QMRP) has the following responsibilities:

- Actively participate in the person centered planning process.
- Provide supervision and training to direct support staff regarding implementation of person centered plan.
- Design support and teaching strategies (i.e. training plans, teaching methods) for implementation. Ensure support and teaching strategies are referenced in the person centered plan.
- Make changes to support / teaching strategies to ensure progress toward achievement of outcomes and action steps.
- Regularly monitor the implementation of the person centered plan.
- Make necessary changes to the person centered plan outcomes based on collection of data, direct support staff feedback and observations of the consumer working toward plan outcomes. Outcomes may only be changed with the approval of the person, their guardian and other members of the interdisciplinary team.
- Ensure that services and supports are provided as specified in the person centered plan.
- Provide service coordinator with monthly reports on progress.
- Facilitate opportunities for natural supports.
- Document specific QMRP activities provided to the individual.

Section II - Developing the Plan

PERSONAL PROFILE

This information is not a mandated form or format for planning**.** The headings listed do not have to be used in a plan. Information may be in a narrative format or any other form that makes sense to the person as long as the required information is included.

The term mandatory means that the topic is required. Optional means that addressing the topic is left to the choice of the person and/or their guardian. Contingent means that if appropriate to the person and situation, the topic is required.

Special Note: See Introduction of planning guidelines page 3 for initial plan requirements. Examples for each section of the guidelines are located in the Appendix B of this document.

1. Demographics:

• Full Legal Name	Mandatory
• Nicknames	Optional
• Age and/or Birth Date	Mandatory
• Primary Language Used	Contingent (Required if the primary language is other than spoken English. If sign language is used, state what type of sign.)
• Method of Communication	Contingent (Required if the primary mode of communication is other than speaking: communication boards, etc.)
• Diagnoses*	Contingent
• Personal Plan Meeting Date	Mandatory
• Personal Plan Implementation Date	Mandatory

*If a diagnosis is listed, the plan should also indicate if there are related supports that need to be in place. Example: If a person has a diagnosis of Diabetes, supports should be listed under "What supports are needed for health."

See Appendix, Example 1.

2. Contributors (Information about this topic is mandatory.)

People we support sometimes do not understand that they may choose who contributes to their plan and attends their planning sessions. They may need to be taught that their friend from work or the person they are dating may be asked to come to the meeting or contribute in other ways. Having a variety of individuals who know and care about the person assists in developing a clear picture of the whole person. These individuals can provide access to information or viewpoints we may not otherwise have.

- **Who contributed to the plan through interviews, reports, letters, questionnaires, etc.?**
- **Who was present at the plan meeting?**

See Appendix, Example 2

3. **Who is important to the person:** It is important to know about the person's social support network. This includes who is important to the person, what the person likes to do with them and about how often. Information about this general topic (important relationships) is mandatory; however, the detailed information is expected to vary significantly.

• Statements from people who know and care about the person	Contingent
• Information about family including names, ages (if children), relationship to the person, the person's level of interest in maintaining or building a relationship with the family member	Contingent
• Information about friends & neighbors	Contingent
• Information about community members and how the person knows them	Contingent
• Paid staff who are important to the person	Contingent

You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Examples 3 – 6.

Information discovered under the following topics must be synthesized in a way that will guide planners, the person and their support staff in developing outcomes that will have a real impact on the person's life. Uncovering a person's gifts and abilities, looking at potential contributions the person can make and knowing how they are best supported will lead us to places in the larger community where the person's identity can truly emerge through the development of valued roles, relationships, meaningful activities etc:

- What is important to the person?
- What do we need to know to support the person?
- What supports are needed for health?
- What supports are needed for safety?

4. What is important to the person: Information about this topic is **mandatory**. However, the specific kinds of things covered are expected to vary significantly.

This topic should include a description of what the person thinks is important to have a reasonable quality of life. **What is important to others should be kept separate. When reading the plan, it should be easy to distinguish what is important to the person from what is important to others.**

Information may be prioritized to reflect what is critical, very important and/or enjoyable to the individual.

You should state information very clearly in order to avoid misinterpretation by support staff. You can avoid misinterpretation by including more than just a list under the topics below. For instance, the plan should not simply state that a person likes movies; it should also explain what type of movies the person enjoys, and when, where and with whom he enjoys watching them.

Hopes, Dreams & Wants	Mandatory
Needs	Mandatory
Likes & Dislikes	Mandatory
What the Person Would Like to Try	Mandatory
Places That Are Important to the Person	Contingent
Special Interests	Mandatory
Traditions	Contingent
Ethnic Heritage	Contingent
Cultural Events	Contingent
Support Preferences (e.g., Does the person prefer a woman or man for specific tasks like bathing?)	Mandatory

When discussing and documenting 'What is Important to the Person?" consideration must be given to not only what is important now, but also what will be important to the person in the future. Having a vision for the future may guide us in understanding what the person needs to learn now or what we need to do now to make future goals possible. "Certain hopes may not always be possible. However, there may be obtainable items or re-occurring themes that can be achieved in that person's life." (Beth Mount)

Knowing how the person's support needs are likely to change in the future may help us prepare for meeting those needs in a timely and effective manner. For example, if we know that a person will need an increased level of nursing care within the next several years we can begin to plan for finding resources to meet those needs, make sure we document relevant information to assist future care givers, make sure supports are in place to help the person cope with the change in their medical status etc. If there are transition issues, such as graduating from school and going to work or moving from a institution to community living , obtaining a vision of what the person would like their future living arrangement or job to be will help us to plan and provide supports that will lead to a future that is desirable to the person.

There is an expectation that information here will be acted upon, if not now, then by a specified time period. You should revisit future needs, dreams and goals as part of the monthly review.

You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Examples 7 A – B.

5. What do we need to know in order to support the person? This information describes what "OUR" behavior needs to be to support the person and is **mandatory**. Information should be based on what the person has told us is important. Staff roles and responsibilities when providing supports could be explained here. It may be helpful to develop a list of all of the items in the support section that need monthly follow-up to assist staff in providing support and to ensure that supports are being addressed and maintained. This information must include:

- A description of how supports should be delivered.
- How a person learns best.
- If the person has behavioral concerns, they may be described along with what we think the person is trying to communicate through this behavior.
- A description of what alternative skills need to be taught to replace the undesirable behavior should also be included.
- It describes what is already happening and needs to continue to ensure consistency in the way supports are delivered.

Information about things to do, try, and learn or to be enhanced should be addressed in the action plan.

> You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Example 8A

6. What supports are needed for health, if any? The plan **MUST** address the person's health whenever there are important issues in this area. This information is contingent in that it is only required if the person has needs in this area.

One way to address health issues is to add a heading to the plan called, "What we need to know for (the person) to remain healthy or meet his/her health care needs." Information should be stated very clearly so that support staff know exactly what must be done to address each health concern. Additionally, information may be included about maintaining good health and might include things such as exercise programs.

A person may choose not to have intimate health or personal care issues detailed in their plan. However, support information must be available elsewhere and the plan must specify: 1) where the information is located and 2) that staff must use this information to guide what supports they provide. For example, a person may need very specific supports surrounding bathing. He may not want his plan to contain a description of how he is to be bathed. In this case the plan must indicate that: 1) he needs assistance with bathing and 2) staff that are responsible for providing support with bathing must be trained to follow and use the bathing checklist located in the medical record.

Keep in mind that the person may not perceive vital issues of health as important. The plan should still describe the issues of concern while making it clear that the person

does not agree. One way to address this situation is to add a heading to the plan called, "Things we think are important and need to know and/or do even if the person does not agree." The following areas of health should be considered:

- Medical or dental conditions — Contingent
- Needed follow-up — Contingent
- Medications, treatments, or procedures (Information should include reason for taking medication, possible side effects, etc.) * — Contingent
- Infection control issues — Contingent
- Immunization needs — Contingent
- Dietary needs — Contingent
- Allergies — Contingent
- Issues around how medical/dental supports are to be provided. — Contingent
- Issues around Mental Health — Contingent

There are a variety of ways that the usage of medication may be addressed in the plan. A list of routine medications and the reason for taking them may be contained in the plan or you may reference that the individual is taking medications for a particular reason and indicate where a list of current medications may be found. Monthly reviews should reference concerns with or changes in medications,

> You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) if there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Example 8B

7. What supports are needed for safety, if any? This information **MUST** be included <u>when there is a need to highlight important or extensive safety issues.</u> This information is contingent in that it is only required if the person has needs in this area.
Information should be stated very clearly so that support staff know exactly what must be done to assist the person in staying safe. Keep in mind that the person may not perceive vital issues of safety as important. The plan should still describe the issues of concern while making it clear that the person does not agree. One way to address this situation is to add a heading to the plan called, "Things we think are important or know and/or do to keep the person safe even if he does not agree."

Behavior that puts the individual or others at risk may be described here. The behavior should be described in terms of what the person is trying to communicate through his behavior and alternative skills the person needs to learn to replace the undesirable behavior.

Some examples of safety concerns may be:

- Emergency Safety — Contingent
- Support needed while cooking — Contingent

- Support needed when away from home — Contingent
- Other supports needed in the home (answering the door, etc.) — Contingent
- Behaviors that put the person or others at risk — Contingent

There may be safety issues that are not extensive, but still need to be pointed out. One way to describe these issues would be under the section called, "What we need to know in order to support the person."

Example: John does not pay attention to weather conditions. This may be documented under "What we need to know in order to support John" by stating "Staff always need to remind John to wear a coat outside when it is cold."

> You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Example 8C.

8. Requirements of family of minor child or guardian? If the person is a minor child, information from the parent(s) or guardian **MUST** be included in the plan. If the person is an adult with a guardian, information must be included if the guardian requests that it be included. The action plan should then describe how the guardian's concerns are being addressed.

There may be situations where it is necessary to include information regarding what people need to know or do that the person disagrees with. Information such as this should be included in the plan but it needs to be made clear that the person does not agree with what is written. One way to provide clarity would be to include a section titled "Things the guardian thinks are important and that staff need to know or do, even if the person does not agree." Health or Safety issues that must be addressed to support the person in staying safe, but that the person does not consider important may be included here.

- Parents of Minor Child — Mandatory
- Guardian — Mandatory

> You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Example 9A

9. How the Person Communicates

This section is contingent, based on the needs of the individual. A communication section is recommended for those people who have their own unique way of communicating. It is very useful when people do not use words to talk or who have difficulty in using words. One way people communicate is through behavior. It may be important to chart certain behaviors and what the person is trying to communicate in order to reduce incidences of unacceptable behaviors. The chart may help us to understand the communicative intent of the behavior and actually gives us cues when some type of redirection, other non-intrusive form of behavioral supports, and/or teaching new skills could be used successfully. Many of the individuals with whom we work are very articulate; however have difficulty expressing their emotions or feelings with words. Often it is their body language that communicates that clearly something is troubling them. If these types of behaviors are clearly outlined in this section, it may prevent an escalation of behaviors.

In these cases it may also be necessary to teach alternative methods of communication. If this is the case, the desired outcome and teaching method should be described in the action plan.

There are many people who communicate very well using sign language or augmentative devices. This section is not needed for these individuals, but rather only for those people who have significant communication difficulties. Document situations where the person successfully uses alternative ways to communicate under Section 1, "Demographics, Method of Communication." (See page 10 of this document.)

An example of a communication section follows:

When this is Happening	And Sue Does this	We think it Means	And We Should
Sue comes home from visiting mom	Slams the door and goes to her room	She is upset about having to leave her mom. She misses her.	Make sure she has space until she approaches you. Give her a hug. Spend time with her doing something she enjoys (puzzles, having an ice cream, sitting on the porch).
Sue is eating	She turns her	She is finished	Remove my food now. (If

	head		you do not remove the food, Sue will throw her plate on the floor.)
Sue goes into the community	She points to her communication board	Sue needs to communicate with someone	Explain to the listener that Sue communicates with her communication board. Make sure Sue has her communication device at all times in the community.
Sue's communication device does not meet her need for a particular conversion / event	Sue shoves the board away	This device is not able to convey my thoughts!	Help her program her communication device or assist her in being able to communicate in a different way.

You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) if there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Examples 10 A – C.

10. Issues to be resolved/concerns

This section is optional. This topic provides a vehicle for documenting differences of opinion among members of the team or circle of support. For example:

- The person wants one thing and the guardian wants another. (E.g., the person may wish to move back home, but the family does not want this to happen.)
- There may be a lack of information about a particular situation, (e.g., a guardian has requested that the person not have contact with a particular person, but no one knows why.) or
- There is a limited availability of options that may hinder immediately working towards an outcome. (E.g., the person wants to live in his own apartment, but needs to find a roommate to share expenses and defray staff costs.)

If there is a disagreement about if or how something should be done or if more information is needed, the plan should describe a strategy for resolving the conflict or obtaining additional information. The plan should include time lines for resolving the issue.

You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Example 11

ACTION PLAN

Action Plans are mandatory. The action plan describes what the person wants to learn, do, change or maintain with the assistance of his support team. It must list what staff will do to support the person, who will do it and a target date for accomplishing each support step. The action plan should be clear so that those providing support will know exactly what needs to happen for the person. A few words to describe an outcome include: the result, the "big picture," the ultimate place to be. **Action plans that contain only a list of services to be purchased DO NOT meet HCB Waiver or Person Centered Planning criteria.** Services are a way of impacting people's live. The impact that the service has should be your outcome, not the service itself. Points to remember about outcomes:

- An outcome IS NOT a service or service definition such as "will receive residential habilitation". Hopefully, the result is not the residential habilitation but **how** this service impacts the person's quality of life.
- An outcome IS NOT a support statement such as "will continue to received 24 hours support from staff"
- An outcome IS NOT the action, but represents the result or "big picture". Services are not outcomes.
- The action plan contains: action steps and support strategies. This is the action it will take to make the outcome a reality.

Each action plan <u>must</u> contain the following information:

1. What Needs to be Maintained/Enhanced or Changed/Different: **Begin action planning by reviewing what you have learned from the information gathered in the profile. In this part of the action plan, you compare the present (what is happening) with what should be happening. Determine what needs to be maintained/enhanced and what needs to be changed/different. You should already have this information if you have completed the assessment questions at the end of each profile topic (Above). If you have not already conducted this assessment, do so before writing outcomes and action steps.**

   There may be times when family or staff feel something needs to continue (such as the person receiving psychotropic medication) that is not important to the person. It should be clear whose perspective is being represented in the plan. The chart that follows is an example of one way to organize this information:

	What Needs to be Enhanced/Maintained? (What makes sense)	What needs to be Changed/Different? (What doesn't make sense)
From the Person's Perspective?	• Continue to go to his brothers each Sunday to watch football. • Staff needs to remember that John showers right when he comes home from work. • Continue to live in the Independence area by his brother.	• Would like to see his mom more, but she lives an hour away and does not have transportation. • Would like to look for another job, as he does not like the workshop. • Staff need to understand how he communicates.

The information in this chart should then be used to develop the outcomes and action steps.

2. Your next step is to use the information gathered above to develop outcomes. The outcomes should reflect the personal profile and what needs to be maintained or changed/different. You need to include rationales stating why the outcome is important to the person. These rationales may be stated as part of the outcome or included in the profile of the plan.

   Having a direct link from the action plan back to the plan's profile and to what needs to be maintained or changed/different helps to ensure that we are supporting the person in learning and doing the things that he feels is important. The action plan may describe what the current situation is and list ideas to change the situation. This list of ideas should be part of the action steps. Staff should have a way of determining if there is movement towards accomplishing the outcome. If staff cannot measure whether something is happening for a person, it could be because the outcome is not written clearly enough.

3. **The action plan must describe strategies for providing the supports a person needs to work towards outcomes and to assure health, safety, and welfare.**

   The action plan needs to state what issues the person has in these areas. It also needs to state <u>specifically</u> what will be done to support the person to stay safe or to maintain health. These action steps should tell us how and what a person or their support staff will do to achieve the outcome related to health or safety. The strategies described should be specific enough that those unfamiliar with the individual can read it and determine exactly what must be done to provide support.

   Sometimes a person may choose to keep very private information separate from the rest of the plan (e.g., a description of how he wants to be bathed). This is acceptable; however, the plan must make it clear that this information exists and state where it may be found.

4. **An action plan must include the names of persons responsible for implementation of each action step and time lines.**

   The person supported and/or a guardian needs to know who is supposed to be held accountable for ensuring each specific support is provided, who he may go to for assistance, etc. This may be the direct support person in the home or someone else designated by the agency who is responsible for making sure action steps occur. Staff needs to know what specific tasks they are responsible for.

   Timelines should be specific and should vary according to how complicated the tasks are. For instance, if a person has a goal to learn to drive, it may take only a day to go to the license bureau to pick up a book for the person to study, but it might take several months for the person to actually prepare for the test. Service coordinators can then use this information to check on the progress of each action step during the review process.

5. **Each outcome should include a statement describing what achievement of the outcome will look like. How would an outside observer know it had been achieved?**

   For instance, if a person expresses a desire to improve their relationship with a family member we might know this has been achieved through a variety of ways. The family member may initiate visits more often, send birthday gifts and/or appear more comfortable with the person as evidenced by sharing memories and laughter. It is important to understand exactly what we want to achieve and when it is achieved so that successes may be celebrated.

See Appendix, Example 12 A - D

LEGAL ISSUES

This section is mandatory.

1. Legal status

2. Guardianship: Name, address, phone number and relationship to the person of the person's legal guardian, if applicable

3. Specific restriction(s) placed by the court such as whether a parent is able to visit a child who has been removed from their custody.

4. Specific restriction(s) to legal rights, documentation of due process, length of time restriction(s) will be in place and, if appropriate, positive behavior support information. The plan should indicate what skills need to be learned so that rights may be restored, how these skills will be taught and what steps will be taken to restore the person's rights when the restrictions are no longer necessary,."

5. Consent for Treatment: Signature of the person and, if appropriate, their parent or legal guardian signifying their consent for the treatment prescribed in the completed plan. The plan must be signed prior to the date of implementation as consent for treatment is <u>not</u> in place until the plan is signed and dated. <u>The</u>

person and their guardian must be given a copy of the plan. The regional center must be able to document that the person and guardian have been sent a copy of the plan. The following statement must be on the signature page:

"My signature below gives consent for service delivery as outlined in the personal plan dated _____, which I have reviewed and approved. (RSMO 633.110)"

6. Other Required Signatures: Signature of service coordinator and/or the regional center representative is required along with those listed under Consent for Treatment.

7. Provider Choice: If this section is included in the plan, the signatures of the person and/or their legal representative must be on the same page as the statement of provider choice. Including this information in the plan does not eliminate the need for the regional center to document choice through the Client Choice of Provider Statement (Form Number 650-7642).

Recommended Readings on Person Centered Planning:

- **Smull, Michael, Sanderson, Helen, & Harrison, Susan** 1996 Reviewing Essential Lifestyle Plans: Criteria For Best Plans. Michael Smull, 3245 Harness Creek Road, Annapolis, MD 21403
- **Mount, Beth and Zwerk, Kay** 1989 It's Never Too Early, Its Never Too Late A Booklet About Person Futures Planning. Metropolitan Council Moers Park Centre, 230 E 5th Street, St. Paul, Minnesota 55101

- **DiLeo, Dale** 1994 Reach For the Dream! Developing Individual Service Plans for Persons with Disabilities, Second Edition. Training Resource Network, PO Box 439, St Augustine, Fl 32085-0439
- **Mount, Beth 1995** Capacity Works: Finding Windows for Change Using Person Futures Planning. Graphic Futures, 25 West 81st St, 16-B New York, NY 10024

PERSON-CENTERED PLANNING GUIDELINES

APPENDIX

PERSON-CENTERED PLANNING GUIDELINES

APPENDIX A

_____ Initial Determination _____ Annual Re-determination

Evaluation of Need for an ICF-MR Level of Care and Eligibility for the MRDD Waiver

Person_____ DMH#_____

New Date of Eligibility for Waiver_____ Regional Center_____

The purpose of this form is to determine and document whether or not the above named person has a need for the level of care provided in an ICF-MR and if so, would he or she require ICF-MR placement if not provided services under Missouri's Home and Community Based Waiver for persons with developmental disabilities.

I. Is the person eligible for ICF-MR?

A. Diagnostic determination of Mental Retardation or a Related Condition which would otherwise qualify him/her for placement in an ICF/MR:

1. Diagnoses: Axis I_____ Axis II_____ Axis III_____

2. If the diagnosis is of a related condition, document the person has functional limitations in THREE (3) or more of the following areas of life activity or, if a child, has or is likely to have, functional limitations in at least three equivalent, age appropriate major life activities:

Self Care ____ Learning ____ Self Direction ____
Capacity for Independent Living ____
Receptive and Expressive Language (development & use) ____ Mobility ____
See Attached (children only) ____

B. Does this person have a need for a continuous active treatment program, including aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed towards the acquisition of the behaviors necessary to function with as much self determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status? YES___ NO_____.

Indicate, by checking below, the limitations this person has which require active treatment:

____ Medical: Has a medical condition that requires ongoing treatment and support.

____ Behavior: Engages in behaviors that are aggressive or self injurious and therefore requires support from staff to encourage positive social interactions and to prevent injury to self or others.

____ Communication: Due to limitations in hearing, speaking, reading and/or writing this person has difficulty expressing or understanding written and spoken communication.

____ Cognitive abilities: Difficulty in processing and understanding information. The rate at which this person learns may be considered slow and creates difficulty in acquiring complex skills.

____ Daily living skills: has difficulty carrying out age appropriate daily routines with regard to personal hygiene, financial management, household chores and/or nutritional needs.

____ Motor development: has difficulty moving about independently and safely resulting in problems accessing the community, operating household equipment and or performing activities of daily living.

_____ Socialization: does not possess adequate social skills necessary to establish and maintain Interpersonal relationships with peers, relatives, co-workers and other community members.

____ Other (specify):_____
_____

II. Is there a reasonable indication, based on your observation and assessment of this person's physical, mental and environmental condition, that he/she will need placement in an ICF/MR unless provided home and community based services under the waiver? YES____ NO____

Summarize the information that supports the above conclusion:

_____
_____
_____
_____
_____
_____
_____
_____

III. List below all assessments and evaluations on which you based the conclusions above. For each entry, document the type of evaluation/assessment and by whom and when it was completed. In addition, for evaluations/ assessments which were performed over 30 days prior to this level of care determination, also document the date you reviewed the information and on what basis you believe it is still accurate.

_____
_____
_____
_____
_____
_____
_____

ATTACH ADDITIONAL DOCUMENTATION IF NECESSARY

This information is maintained where? _____case record, ____other location (specify)

_____

IV. _____ _____ _____
Signature Title Date

PERSON-CENTERED PLANNING GUIDELINES

APPENDIX B

INTRODUCTION

INTRODUCTION

The overview section of the Guidelines Manual explains the requirements of the Department of Mental Health, Division of MR/DD regarding personal plan development. The values of the Department are in accordance with the Missouri Quality Outcomes; therefore, personal plans must also be in accordance with these values.

What are the Missouri Quality Outcomes?
The Missouri Quality Outcomes is the result of listening to people with disabilities and their families. It describes a collection of positive outcomes identified by people with disabilities. This collection is in the form of a discussion guide that is intended to serve as a tool to put into practice what individuals tell us every day:

- To have productive, meaningful lives
- To be full members of a community like any other citizen
- Typical life in the community is the benchmark for quality life

Outcome #11 of the Missouri Quality Outcome states:
"*People's plans reflect how they want to live their lives, the supports they want and how they want them provided".*

Why guidelines?
The person-centered planning guidelines are a balance between "system requirements" (what is required for funding for developing person-centered supports and services) and "best practice" for developing person-centered plans. The goal of the appendix is to assist teams, planning facilitators or anyone in need of understanding the personal plan process with developing supports and services through the Division of MR/DD. The personal plan process is a framework for discovery, decision making, understanding and learning about a person, and a means for taking action to assist a person to build a desirable future that makes sense to him/her. The guidelines are a means of getting started with this process.

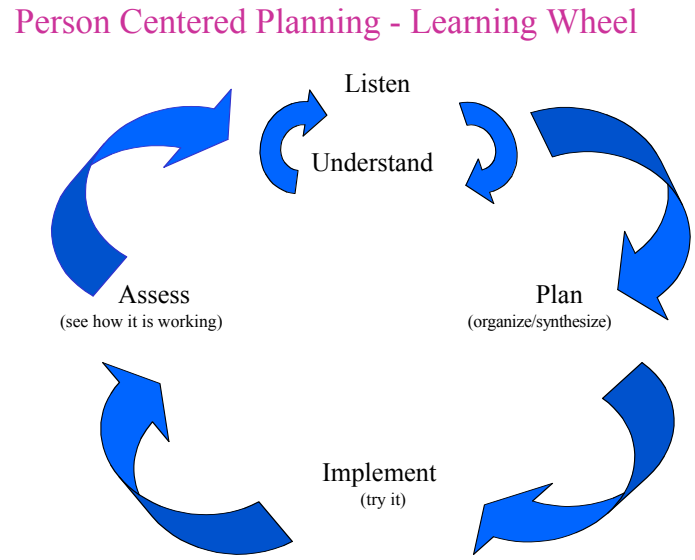
A process for person-centered planning is adopted by many states as a means of defining how supports and services are delivered and to define state values. Other states have also established *guidelines* for personal planning to ensure plans implement values of self-determination.

Principles of Self-Determination:

FREEDOM
To live a meaningful life in the community
AUTHORITY
Over dollars needed for support
SUPPORT
To organize resources in ways that are life enhancing and meaningful
RESPONSIBILITY
For the wise use of public dollars
CONFIRMATION
Of the important leadership that self advocates must hold in a newly designed system

Defining the process:

The term "person-centered planning" became common by the 1980's. It represents an approach for seeing the person first rather than relating to a diagnostic label, using ordinary language rather than professional jargon. The process actively searches for a person's needs, gifts, interests, capacities in the context of community life, and it should strengthen the voice of the person and those who know the person best. This process evaluates the person's current situation to **define what health, safety and risk means** for the person and seeks a desirable change that makes sense *to* and *for* the person.



- *Smull, Allen - The ELP Learning Community*

The Centers for Medicare and Medicaid Services (CMS previously known as HCFA), also defines and adopts the person-centered planning process / values as a means for providing supports and services to individuals. (This is described in the overview section of the guidelines).

Person-centered planning is viewed as a core component of quality service delivery. The person is the central driving force in determining the future vision, goals, supports and services. It requires the team to do the following:

- Listening to the person and understanding what a *desirable* lifestyle means *to* and *for* the person, always seeking to find the *balance between* health, safety, and risk issues

- Plan means to attend to the details (develop the document), identify the supports and services that really matters *to* and *for* the person, encourage the contribution of the person's dreams and desires, and be open and sensitive to situations that can be difficult and confusing

- Implement and assess means the outcomes are in "active" status, the team asks the following questions: what have we learned, what have we tried, what needs to be changed, enhanced or maintained? The answers to these questions are acted on to determine what's working or not in the life of the person, the plan changes as the person's life changes.

PERSON-CENTERED THINKING:

The person-centered process is a shift in the way we *think, what we do, and how we do it* ("person-centered thinking") and specifically *how we do business* in supporting people with disabilities. We are constantly challenged by the work we are required to do within "the disability system" which often makes it difficult to balance the values we must practice to truly do good person-centered work.

The following examples describe some of the differences between traditional and current practices in the way we should *think, act, and do business* in a person-centered way.

Traditional Process	Person-centered process = person-centered thinking and planning
A team of service providers meets annually with the individual and/or family members to develop a plan for services.	A support team made up of the individual, legally authorized representative, family members, service providers and other community members meet as frequently as needed to develop and implement a future vision and goals for the individual. The team will meet based upon the needs of the individual, but at least annually.
Relies only on standardized and non-standardized tests and assessments that highlight deficits. Looks at the person in need of services and who has to get "ready" for community life.	Spends time getting to know and discovering the person. The support team gathers and organizes information into a personal profile, develops the future vision and outcomes with action steps that leads to achieving the outcome.
The individual and family members participate in the development of a service plan.	The team assists the individual in a respectful and competent manner to actively lead and/or participate in the meeting.
Establishes goals that are already part of existing programs. The plan is designed to fit the person into a particular program even if that program is not exactly what the person needs or has interests.	The individual, family members, friends, and general community members define the personal profile and future vision and look to service providers for supports. Programs are developed around the needs of the individual.
Relies primarily or solely on professional judgment and decision-making.	There is shared decision making with the person, families, friends, and those who provide supports and services.
A service plan is mandated that guides the services received. The service IS the outcome.	The content of the plan provides a snapshot of the person and drives the need for outcomes and action steps. The action taken drives the supports and changes to be implemented.
Implementation of the plan is ensured through provisions of professional services.	Implementation of the plan depends upon the commitment and partnership of the team and their connections with the individual.
Goals are developed based on "programmatic" needs.	Outcomes are developed based on: • The person's current situation • What's working vs. not working in the person's life • What is important *to* and *for* the person • Things that need to be changed, maintained or enhanced in the person's life • Values of the Missouri Quality Outcomes ("typical" life in the community)

To self-advocates and families:

Signs of adequate planning and support for self determination: (adapted from "It's my meeting – a family and consumer guide to participating in person-centered planning)

- Team members are active listeners, understand who you are, what you need and want in your life.
- You are supported to express yourself.
- Decisions making is shared.
- There is shared understanding of advice given to you (and/or your representative).
- Choices are provided (to you and/or your representative).
- You (and/or your representative) are comfortable with the time and place of the planning meeting.
- You chose and are aware of all participants on your team.
- The planning document reflects your needs, desires, preferences, capacities and states your desired outcomes for reaching your goals (long and short-term).
- The planning document is changed and/or updated as often as your life changes or as often as you request.
- The planning document is not impersonal or disrespectful.

LIFE TRANSITIONS

A VISION FOR THE FUTURE

Person-centered planning and life transitions:

Person-centered planning is also a process to support an individual in transition. Transition examples include:

- Graduating from school, transition to adult life
- Finding employment or changing jobs,
- Moving to a new home (from a parent's home, institutional setting, nursing home, hospital, etc.) to life into the community,
- Living with someone new,
- Coping with the death of a loved one
- Health changes and/or aging issues
- Retirement
- Locating a provider agency,
- Meeting new people, trying new things, and going to unfamiliar places, etc.

The purpose of a person-centered transition planning process is to ensure all team members involved are on the same page, share the same vision and commitment for change. Teams also must make sure valuable and complex information is shared (such as what is important *to* and what is important *for* the person regarding supports, services, health, safety and risk) during the transition.

Transition planning should be a purposeful, organized and outcome-oriented process designed to ensure the person's quality of life. It is very important to begin early to allow time for planning the supports and services needed for the future.

Any transition process can present complex issues and anxiety for the person. It can also be a traumatic experience to the person which means it is critical that planning teams address all sensitive areas to meet the needs and preferences of the person. It is also critical that those who know the person best from all settings participate in the planning process.

The components outlined in the *person-centered guidelines* can assist with developing a good initial transition plan.

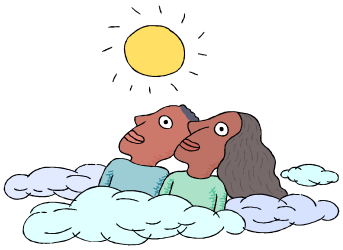
General guiding principles of transition *(Adapted from "Best Practices for Transition Services" – California Transition Coalition)*

⇒ *Implement person-centered planning*
⇒ *Focus on the person / family*
⇒ *Ensure the health, safety, and well-being of the person in transition*
⇒ *ONE PLAN in transition with the person*
⇒ *Focus on outcomes*
⇒ *Improve quality of services*
⇒ *Provide user friendly and culturally sensitive services*
⇒ *Be cost effective*
⇒ *Ensure collaboration between and within agencies*
⇒ *Provide opportunities for interagency training, accountability, and shared resources*

The Community Transition Guide in Missouri:

The purpose of this guide, developed by the transition team in St. Louis, was developed as a tool to assist teams in the transition process for individuals moving from the habilitation centers to community life. The guide provides detailed information about the *requirements and process of transitioning* in Missouri and describes the roles and responsibilities of the transition planning team.

Transition teams have the option of utilizing this guide which is also available on the department's website.



A vision for the future:

When a person is in transition, this means change. Each time we plan with someone, we should seek ways to develop a vision that should ask the person and his/her team: Where does the person want and/or need to be 30 days from now, 60 days, 90 days, 6 months, 1 year, 3 years from now, etc.? It may take that long for long range goals to become a reality.

A person may not articulate what they want for their future; therefore, the job of the team is to find the best "informants". Those who know and care about the person may need to make their "best guess". In order to develop future planning we need to understand what is most important to the person. The team needs to also identify the support needs, obstacles, health, safety and risk issues for the person. Outcomes and action steps should be directed toward reaching the vision.

Consider the following examples of statements that should not only be included in the plan but should lead to "future planning" outcomes and action step or long range goals outlined in her plan.

- Jennifer and her family's goal for the future are for Jennifer to move into the community from the habilitation center by May of 2005.
- In the next few years, Jennifer will approach her dream of moving from the group home to living in her own apartment with 2 other people.
- Jennifer and her family wish to pursue Jennifer moving out of the family home within the next year. They are interested in seeking all available options.
- Jennifer would like to find employment other than the workshop.
- Jennifer would like to plan for retirement from the workshop by December of 2005.
- Jennifer would like to save her money to plan for a vacation for the summer of 2005.
- Jennifer's family would like to pursue a change in guardianship from her aging father to her sister who lives in another state.

EXAMPLES

The following pages provide examples for each section of the guidelines:

I. PERSONAL PROFILE

A. Demographic page
B. Documenting contributors
C. Who is important
   Relationship map or narrative format
D. What is important (including transitions and vision for the future)

II. SUPPORT SECTION

A. In everyday life – basic needs
B. Communication
C. Health needs
D. Environmental / safety needs

III. REQUIREMENTS OF FAMILY OF MINOR CHILD OR GUARDIAN

A. Relating to "what is important" section or
B. Relating to "support section"

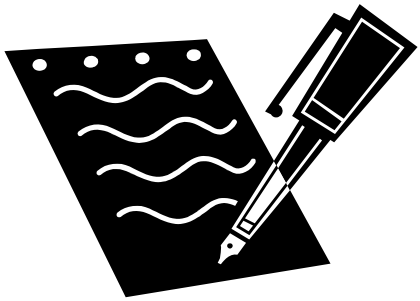
IV. ISSUES / CONCERNS

V. ACTION AND OUTCOMES

A. Defining action planning components
B. Different perspectives: using what makes sense (what's working), or doesn't make sense (not working) to develop outcomes
C. Examples for each component: outcome, current situation (or justification), action steps, strategies, measuring for success.

Personal Profile:

DEMOGRAPHICS CONTRIBUTORS



Example 1: Sample Demographic page:

AAA REGIONAL CENTER

WAIVERED CLIENT: ☒ **NON-WAIVERED:** ☐
NORTH: ☒
SOUTH: ☐ **SERVICE**
EAST: ☐ **COORDINATOR:**

NAME: Sharon Doe **DATE OF IMPLEMENTATION:**
DMH I.D. #: 014-000000 **DATE OF ANNUAL REVIEW:**

DIAGNOSIS: **AXIS I:** No Diagnosis
AXIS II: Severe Mental Retardation
AXIS III: No Diagnosis

COMMUNICATION STYLE:

MEDICARE #:

MEDICAID #: 00000000

SOCIAL SECURITY #: 555-55-5555 **DATE OF BIRTH:**

CLIENT ADDRESS: **COUNTY:**

CLIENT PHONE:

CONTACT/FAMILY:

CONTACT/FAMILY ADDRESS:

CONTACT/FAMILY PHONE:

GUARDIAN: **COUNTY:**
GUARDIAN ADDRESS:
GUARDIAN PHONE:

AGENCIES PROVIDING SERVICES	INITIATION DATE	REASON FOR SERVICES
ABC Regional Center	09-02-2003	Service Coordination
XYZ Services	12-10-2001	Residential Habilitation
ABC Industries	2-15-1995	Sheltered Employment
YYY County Board of Services	2-15-1995	Transportation

Example 2: Contributor / Sign-in sheet:

The contributor / sign in sheet is a way to document the contribution of information and/or attendance all of the people who know and care about the person. The intent is to ensure that all those important in the person's life are provided an opportunity to share information for the development of the plan even if they do not attend the meeting. Information gathering from others can be done by phone, questionnaire, meeting in person other than the plan meeting date, etc.

NAME:	**I.D.#:**	**DOB:**

PLANNING TEAM MEMBERS: (The following individuals provided input into the development of this plan).

NAME	***TITLE/*** **RELATIONSHIP**	**AGENCY**	**DATE PERSON PROVIDED INPUT**	**ATTENDED MEETING?**	**SIGNATURE**

Personal Profile:

RELATIONSHIPS

NETWORK OF PERSONAL RELATIONSHIPS AND VALUED ROLES

Missouri Quality Outcome #2: "People have a variety of personal relationships".

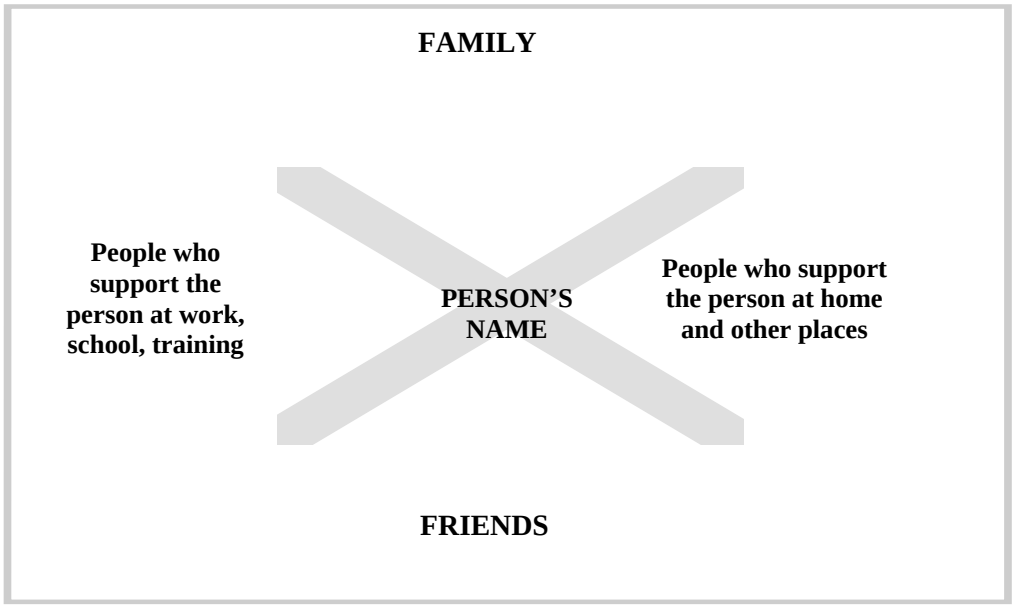
Many people feel that the key to a quality of life rests on relationships with others. Friends, family, neighbors, and acquaintances are important people in our lives. To be valued as a family member, for example, brings family fun, friendships, love and bonding. This includes relationships we develop in familiar places where most of our time is spent with coworkers, classmates, our partners, teammates, housemates, etc. Sometimes a staff person becomes a long term friend to someone they support but it is also important to support the development of diverse relationships with a variety of people. By doing this we can also assist individuals to develop shared experiences, gain access to social organizations, and participate in other "typical" community activities.

Relationship building is essential in person-centered planning because people with disabilities have been at risk of being unseen, segregated and alone. In describing relationships in the plan, this could assist the person and his/her team to look closely at personal networks. We need to determine if there is a possibility to increase opportunities for a person to maintain an existing relationship and to begin a mutual exchange for new social networks in their community.

"We need to belong intimately to a few people who are permanent elements in our lives. A life without people, people who bond with us, who will be there for us, who need us and whom we need in return may be rich in other terms, but in human terms it is no life at all; only our relationships with other people endure."

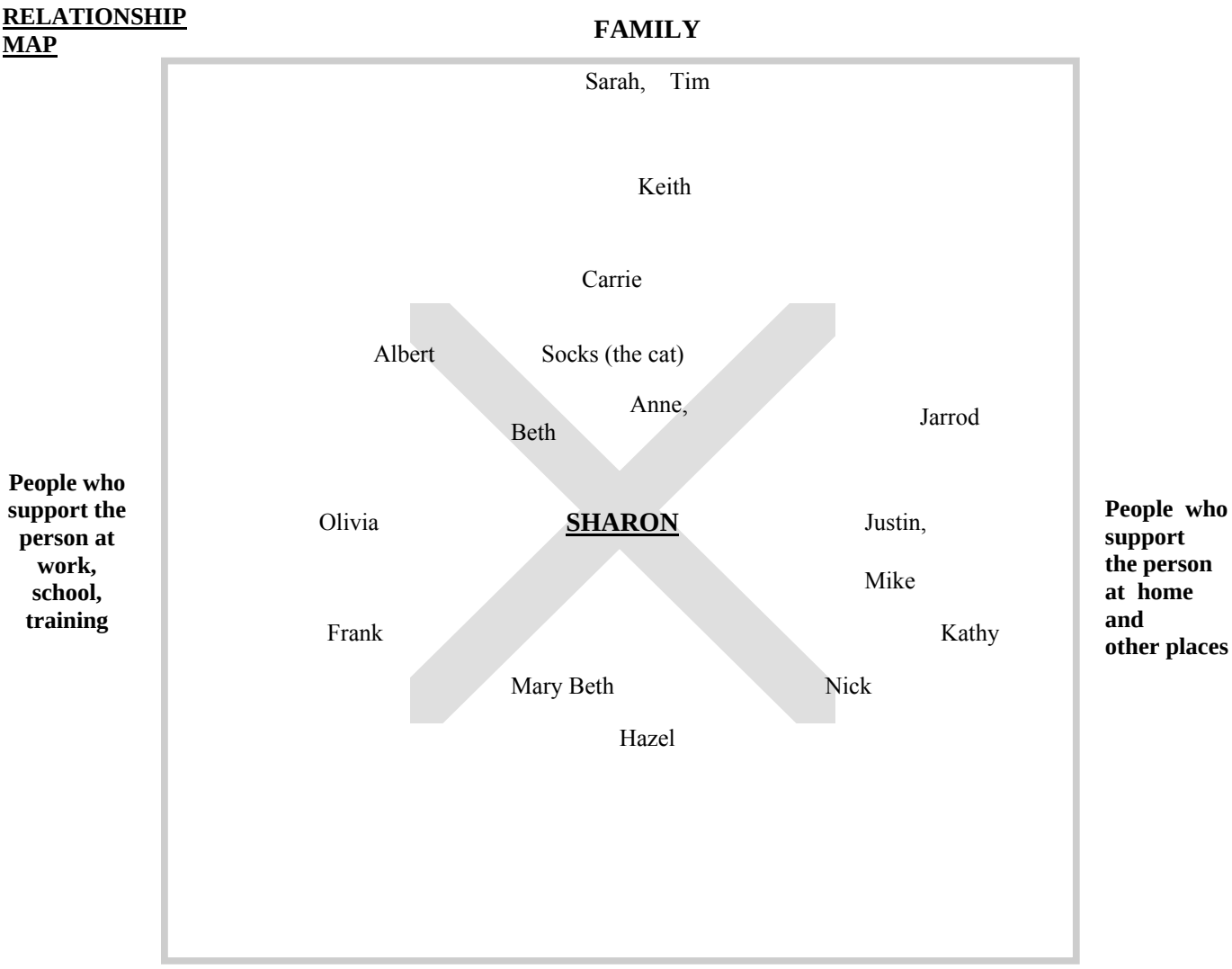
*(*Harold Kushner, "When All You've Ever Wanted Isn't Enough")

Example 3: Relationship Map A



Example 4: Relationship Map B

Example: "Sharon"



THE PROFILE

Example 5: Relationship Map C
<u>"Sharon" in narrative</u>

Sharon has been living in Kansas City since she was 12. Originally she lived with her mom and guardian, Carrie, two older sisters, Anne and Beth and her younger brother Tom. Sharon is very close to her mom, Carrie. Carrie calls every weekend and never misses a birthday or major holiday. Sharon's parents divorced when she was 10. This was very difficult for Sharon. Sharon's dad, Keith lives in Kansas City. Her dad is still very involved in her life and continues to have frequent contact with her. Sharon's dad calls at least twice a month and sends letters, cards and gifts on special occasions. Sharon's favorite is the "balloon bouquet" she receives from her dad every birthday.

Anne is Sharon's sister and lives in Columbia. Anne works during the day, has 2 children. Sharon loves her niece and nephew, Sarah (12) and Tim (19). She has many pictures of them in her home, but would like more pictures for her wallet. She enjoys showing off the pictures of her family and would like others to take the time to talk with her about her family. Tim, the 19 year old, attends college out of town; therefore, he and Sharon do not have much contact. He sees Sharon for most major holidays.

Since Sharon does not read it is very important that staff take time to read letters from family. If Sharon knows a letter has arrived in the mail for her and staff don't take time to help her, she becomes very upset. She may yell and hit the walls to show her frustration. Staff is expected to STOP what they are doing to help Sharon with her mail!

Holidays with family are usually celebrated at either Beth or Anne's home. Sharon's mom always makes sure Sharon attends family celebrations. People who know Sharon say that if she does not see or speak to her family frequently (at least once a week according to her mom), she will become upset. For example, people who know Sharon may notice her paying less attention to her appearance, arguing with her housemate more often or having sleepless nights. Sometimes staff needs to initiate a call to Carrie. Sharon just needs to hear her mom's voice and this usually helps when she becomes frustrated.

Sharon has a cat named Socks. Being able to cuddle with Socks really helps Sharon when she becomes upset. Sharon learned to care for Socks this past year. She knows when to feed him. She learned what it means to have pet vaccinations done and how to take Socks to the Veterinarian when needed. Sharon enjoys taking Socks to PETWORLD to buy food and toys. It is reported that the employees at PETWORLD recognize Sharon as a regular shopper.

Other important people in Sharon's life include her friends from work, Mary Beth, Hazel, Nick, Cal and Anna. They don't visit much after work hours but often see each other during dances and holiday parties. Sharon likes her supervisors, Olivia, Albert and Frank. Olivia is known to be very supportive and keeps in touch with Sharon after work hours.

Example 6: Relationship Map D in narrative - continued
Joan's personal plan - using headings to describe relationships

Some of the PEOPLE who are *MOST* important to Joan

- **FAMILY:**

Peter – Joan's **brother and guardian**. Joan says she also calls him "little brother". Joan sees Peter on weekends and holidays and calls as often as she "feels like it". When she wants to visit, she says she just makes a phone call, usually visits for at least one weekend per month.
Jenny – sister-law and **wife**.
Jim – brother, Joan usually sees Jim when she visits John, especially on special occasions such as Easter, Christmas and Thanksgiving. **Jenny – sister-law** and **wife**.
Juanita - wife of Jim
Uncle Dean – Brother of Joan's father
Helen – sister who lives in Ohio. Joan says she never sees her sister

** Joan's parents (Lil and Joe) are deceased.

- **FRIENDS:**

Charles – Also known as "Chuck". Joan considers her best friend and sometimes her boyfriend. Joan has known Chuck for 5 years, and they also work together.

Louise – Best friend and shares her home and expenses. Joan has known Louise for the past 4 years. They have shared their home together for the past 2 years.

FRIENDS from workshop
Mike, Ron, Rick, Don, and Sylvia

PEOPLE WHO PROVIDE SUPPORT INCLUDE:

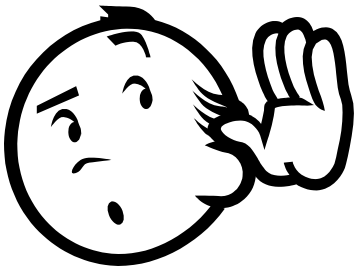
Linda: Workshop Supervisor – has known Joan for the past 6 months. Linda says Joan is a dedicated worker.

Kate: Agency Director – has known Joan for many years. Kate says Joan is witty and has a smile to light up a room. Jake**: Kate's husband, has known Joan for many years, as well. Jake says Joan is a real comedian!**
Darrell: Agency QMRP – has known Joan for the past 2 years. Darrell says Joan is a good friend.
Rebecca: Serv. Coordinator – has known Joan for about one year. Rebecca says Joan is fun to be around.

Jean– Jean is Joan's therapist and has known her for 1 year. Jean says Joan is intuitive and sensitive to other's feelings.

Personal Profile:

“WHAT IS IMPORTANT”



Person-Centered Thinking = People First Language

The profile: "What is important to know about Sharon" sometimes called "Who is Sharon" provides basic information that could include where she lives, works, how she spends her days, who she spends time with (relationship information/map), her history, ways in which others respectfully describes her, her interests, preferences, capacities, things she'd like to do, try or learn, etc.

The purpose of this information is to give an unfamiliar reader a sense that they have just been introduced to the person, to provide a "snapshot" of the person's life. We need to remember the importance of the language we use to describe people. Remember that historically, the language generally used to describe a person with a disability were words that labeled, stigmatized and defined deficiencies. The words we choose to use can reflect the thoughts and opinions of those we write about.

One of the characteristics of person-centered values is the use of everyday, respectful language:

Tip: Talk TO people and families, not AT them. Use "people first" language. Ask "did I get it right?" Pay attention to the cues of "non-traditional," ("non-verbal") language. Don't talk down to people; watch your tone of voice and body language when communicating.

Yes, it is possible to describe issues and concerns without being degrading, or disrespectful to the person. We should also minimize the use of "human service" terminology so that anyone reading the plan can understand its content and intent (i.e.: the person, family members, staff, or anyone else who are not familiar with "system" jargon, etc.).

Tip: Avoid the use of words like "low-functioning" "high functioning", "non-verbal", "non-compliant", "displays inappropriate social behaviors", etc. Instead be as specific as possible, Make sure you balance this information by describing the capacities of the person and specifically define the person's support needs. Describe the person's method of communication, how the person expresses his/her needs, wants, desires, frustrations, and social experiences.

Tip: Avoid describing the person as part of a group. For example, by merely stating the person has cerebral palsy doesn't mean the same for all people. The support needs of one person with cerebral palsy may be very different for another.

We should never hide or "sugar coat" important information that could have an impact in the everyday quality of life for an individual. Health and safety issues must always be shared to ensure the health, safety and well being of the person, those who support the person and community members. It is often difficult but we must **find a "balance"** when sharing important issues in a person's life while being respectful to the person. Information about a person from the past should never be used as a means to label the person when time still needs to taken to get to know the person first especially by new staff. However, historical information can help us to gain a better understanding of the person and to figure out the best way to provide the right supports / services.

"Never become overwhelmed by the endless assessments and professional opinions, stay focused on who the person is, and never loose sight of the fact that first and foremost, we are talking about people's lives……."

(A. Schouten, Parent, excerpt from "A Service Broker Can Make A Difference", Nat'l Program Office on Self-Determination)

Example 7A: "What is important" section of the profile

Who is Sharon?

Sharon is an outgoing 33 year old lady who lives in the south part of the metropolitan area. She shares a rented home with one other person, who happens to be a good friend. They have been living together for the past 3 years. Sharon receives services/supports through XYZ residential services since January 1999 through the individualized supported living program.

Those who know Sharon well describe her as sociable, entertaining, fun to be around, loving and committed to her family. Sharon is fairly easy going but also very routine oriented.

When Sharon moved from her mother's home, Sharon has adjusted well to her environment. Over the past several years, Sharon has taken great pride in her home and her appearance. She doesn't enjoy house chores but she does enjoy the benefits of having her own place and space for everything she owns. Sharon has many possessions (mainly from her giving family) and likes to keep everything organized. She especially takes pride in her relationships with others and likes sharing her pictures; this is Sharon's way of having conversation and getting to know someone unfamiliar.

Sharon does not use many words to communicate (see communication section of plan). However, she does express her needs, wants and desires and clearly lets you know when she is having a bad day. It has been discovered that music, socks (her cat), and phone calls from her mother on a regular basis and her pictures of loved ones helps with maintaining good days.

Sharon works part time at ABC Industries and has been working there for the past 10 years. Since the year 2002, Sharon appears to be easily distracted and bored at work. She has been described as a good employee over the years but the team feels Sharon is loosing interest in the workshop setting. Sharon also enjoys the benefit of working by her excitement over receiving her small paycheck every other week. The team along with the workshop staff supports Sharon to explore other options. Sharon's team is attempting to contact vocational rehabilitation (VR) to seek supported employment options. In the meantime, the workshop agrees that if Sharon could work part time may be the best option. Sharon has been part time for the past 6 months; and appears to be a much happier, outgoing person.

Example 7B: "What is important"
Sharon's personal plan profile - Using heading and bullet points (another formatting option

"What is important to Sharon"

- Sharon enjoys music such as Gospel and country. Her favorites are Garth Brooks and the Dixie Chicks. Sharon enjoys her music especially when she does chores around the house.
- Sharon is also a sports fan. She enjoys baseball (favorites are the Royals) and football (the Chiefs). She enjoys having someone to "talk sports" and she especially likes to stay current on games and information about players, as well.
- Sharon is considered to be athletic. She enjoys playing softball (she is a member of her church softball team). Sharon also enjoys bowling, walking with her roommate and staff and has fun exercising to tapes like Richard Simmons.
- Cooking and helping in the kitchen: Sharon enjoys cooking and would like to lean to prepare different types of dishes.
- Enjoys barbequing for herself and for her friends: Sharon owns a George Foreman grill and has learned to cook hamburgers and brats with assistance. Sharon is a real hostess! Sharon's nephew, Tim was so excited to hear her interest in learning to cook; he purchased the grill for her birthday.

Regarding routine:

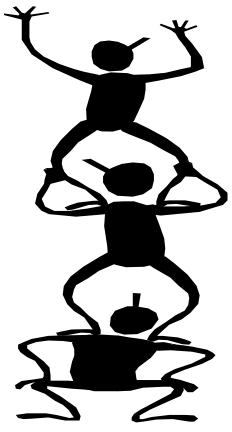
(Note: Sharon is very routine-oriented but she works well with changes as long as she is informed that her regular schedule may be interrupted).

- Sharon works 3 days per week at ABC Industries Workshop.
- A typical weekday for Sharon begins at about 7 am: Sharon does not like to get up early! She showers immediately. The shower helps her to wake up and to "get-going" in the morning. Sharon should never miss taking her shower in the morning.
- Sharon eats a light breakfast, usually toast, cereal or fruit. She can prepare this herself and does so after she showers.
- She doesn't like doing dishes much, but will do it if reminded and while listening to her radio.
- She generally goes out for a walk (weather permitting) in the evening after work and in the morning on days she does not work. She returns home and relaxes for about ½ hour.
- She has lunch about 11:30. She enjoys peanut butter sandwiches, loves soup, Grilled Cheese and ALWAYS wants a glass of milk and water with her meal.
- After lunch she listens to music, does chores (like laundry or cleaning the apartment) or watches a game on ESPN.
- On days Sharon is not working, in the afternoon, Sharon usually goes shopping, pays bills, goes to the park, out to lunch once a week pending her funds, or runs other errands with her staff.
- Sharon and her roommate divide up the chores for the week. Sharon and her roommate generally have dinner together. On Monday evenings Sharon and her roommate (Mindy) are supported to make up the menu for the week. Staff supports them by suggesting side dishes, keeping within their budget and helping them look at sales items in the newspaper flyers. They both enjoy clipping coupons before grocery shopping with staff.
- After dinner, if Sharon has no plans to go out, she and Mindy watch movies, listen to music or play card games like UNO, etc. Sharon always says her prayers before going to bed. Sharon likes to go to bed around 10 pm and will do so with her TV on at a low volume.

Personal Profile:

SUPPORT SECTION

(What do we need to know, what do we need to do to support the person?)



IDENTIFYING SUPPORTS IN THE PLAN

The support section of the plan is a crucial component of the planning process. It is an area that identifies "how" the supports need to be provided. This information was already identified under what is important to Sharon. The support section describes:

- The behaviors of support staff
- Specifics about what works and/or does not work for the person
- The specific strategies or methods that helps the staff to understand health, safety, behavioral or risk issues for the person

Examples 8A-1 – (supports):

- *Make sure Sharon has an opportunity to shower in the morning before she goes to work.*
- *When Sharon is cooking using her George Forman Grill, never leave her alone, although she appears to be very independent, she often becomes easily distracted.*
- *Avoid settings that include large crowds. Sometimes talking to Sharon before an event that may include large numbers of people may help with her feeing some anxiety. Try it, but when Sharon says "lee now!", this is a sign of her feeling anxious, therefore, it's time to leave now!*

These are some examples that require understanding and listening to the needs of the person. The support section could also be a valuable tool:

- For new staff in orientation
- To match the characteristics of staff to the person supported
- As a learning tool for others who know think they know the person well
- When a person is experiencing some type of transition

Example 8A-2 - Other tools to use to describe supports:

When This Is Happening	And Jennifer Does	We Think It Means	And We Should
MEALS / EATING and DRINKING	• holds her cup up at you	• Jennifer wants more to drink	• Provide more to drink (usually water). Remember, Jennifer has NO DIETARY RESTRICTIONS for what or how much she drinks, she really likes water!
	• throws her cup down	• Jennifer has had enough to drink	• Respond by not giving Jennifer more to drink
	• goes straight to the kitchen	• Jennifer is looking for something to eat	• Accompany Jennifer to the kitchen; make sure Jennifer has a choice of snacks. She will respond by pointing to the snack she prefers. • Always provide opportunities to choose

Example 8A-3 - supports are embedded in "What is important to the person"

(This narrative also includes hints on "<u>how to support</u>" Sharon, instead of stating supports in a separate section).

Sharon enjoys helping in the kitchen although it is important that she have assistance from staff while cooking, as she might forget the burners are on or that something is in the oven. Sharon is often sidetracked

if not reminded to check on the food. Sharon's favorite is cooking outdoors. Sharon enjoys BBQ and has learned to make hamburgers and brats on her electric gill. She really pays attention when using her grill. Her brother, Tim bought her a George Foreman Grill for her birthday with utensils and a red Chief's apron, which she wears with pride! She does need help setting up the grill. Sharon really enjoys having family over for BBQ. Sharon wants to learn to make more dishes in the kitchen and on her grill.

Sharon loves to listen to music. She especially enjoys live music, such as an outdoor concert. Sharon does not enjoy live music indoors such as a dance hall where she feels confined or experiences a feeling of being "closed-in". Her favorite music is gospel or country. She listens to Travis Tritt, Garth Brooks and the Dixie Chicks. Staff discovered that it is easier for Sharon to complete undesirable tasks around her home (such as cleaning, doing laundry) while she listens to her favorite music.

Sharon is also interested in Baseball (Cardinals and Royals, her favorite) and Chiefs football. Her roommate does not really enjoy these things and it is important that staff be able to talk with Sharon about current sports events. Sharon is known to be athletic. This year she played softball on a team through the youth league at her church. She really enjoys bowling, walking and exercising to her Richard Simmons tapes every chance she gets. Her friends Mary Beth and Hazel both play sports and are also fellow sports fans.

Sharon works part time, 3 days per week at ABC Industries. Sharon's goal is to someday seek a job elsewhere and her team is helping her to seek support from Vocational Rehabilitation. She has been referred this month. The team feels that the workshop environment does not benefit Sharon. She is capable for other types of employment. Sharon does not enjoy her work but does enjoy the benefits of working by showing excitement after receiving her small paycheck every 2 weeks.

On days Sharon is not working, a typical weekday for Sharon begins at about 7 am: Sharon does not like to get up early! She showers immediately, this helps her to get up and going in the morning. Sharon eats a light breakfast, usually toast or cereal and fruit. She can prepare this herself and does so after she showers. She doesn't like doing dishes much, but will do it if reminded and while listening to her radio. Staff should inform Sharon if she has any appointments for the day or any other event that will be different than her normal routine. If not, she generally goes out for a walk (weather permitting). She returns home and relaxes for about ½ hour. She has lunch about 11:30. She enjoys Peanut Butter Sandwiches, chicken noodle soup, and Grilled Cheese sandwiches and ALWAYS wants a glass of milk and water with her meal. After lunch she listens to music, does chores (like laundry or cleaning the apartment) or watches a game on ESPN. Sharon and her roommate divide up the chores for the week. On days Sharon is not working, in the afternoon, Sharon usually goes shopping, pays bills, goes to the park, out to lunch, maybe once a week, or run other errands. Sharon and her roommate generally have dinner together; they make up menus for the week, clips coupons, or play card games, etc. Staff supports the ladies by suggesting side dishes; assists them to stay within their budget and to look at sales items in the newspaper.

Example 8A-4: "What do we need to know or do to support the person?" Sharon's personal plan (refer to what is important to Sharon, basic supports)

(This example shows a separate section highlighting "how to support" instead of placing in the narrative that describes what is important). This information will provide all those who support her with information about her daily needs and what they need to know or do to make sure her daily needs are met.

Although Sharon can prepare some meals and snacks on her own, she needs support for safety reasons. When Sharon is cooking or grilling, she requires supervision, for now. She might forget the burners are on or that something is in the oven. Therefore, staff needs to pay attention. Sharon gets sidetracked when she has too many tasks to do at one time, therefore, simply remind her to check on the food etc. Sharon has shown to be more attentive when cooking on the grill. Make sure Sharon has only one task to do at a time.

Sharon does not like to feel closed-in and does not enjoy crowds of people in a confined area. Staff may need to talk to Sharon about an environment prior to the trip or provide her the time to get used to the new environment. Sharon will let you know if she is uncomfortable, such as yelling, or hitting things such as a chair, or any other object near her. However, be prepared to leave immediately once she says she needs to leave. When Sharon yells, "lee now!" (meaning: leave now!), don't spend time trying to talk her into staying. This will escalate her anxiety to leave. Staff reports that Sharon does enjoy outdoor concerts, irregardless of the crowds, therefore, you never know, just take the time to try it and respect her feelings once she expresses herself to you.

Sometimes Sharon will choose not to do her part when doing household chores. One thing that staff discovered, it is easier for Sharon to complete "undesirable" tasks around the apartment (such as cleaning, laundry) if her favorite music is playing. Start out by staying upbeat. Then, ask Sharon if she'd like to play a CD, tape or listen to her favorite radio station. Then, remind Sharon about the activities and responsibilities she committed to with her housemate. Say, "Sharon, together we can do _____ while the Dixie Chicks are playing".

When doing chores, it is very important to talk about things Sharon enjoys, such as current sports, news and events or just listening to music. Keep it fun, be talkative. This will help Sharon to look forward to the next task.

Example 8B: What do we need to know or do to support the person (to stay healthy?)
Sharon's personal plan

- Sharon enjoys exercising and is recommended by her physician to try loosing 15-20 lbs. Sharon often complains her legs hurt and tires easily. A consult with a dietician is recommended. Her physician also recommends that a low impact exercise regiment to help with weight loss. He is pleased that Sharon tries to walk daily but suggests that she might try increasing her distance by one more block. Various tests were completed during her physical on 1/15/04, to ensure no other problems were occurring. To date, no other concerns are noted. Sharon and her staff need to report to Dr. Jay, in one month, to follow-up on her progress. Sharon is NOT on a "special diet" but just needs watch her portions and to continue exercising as she does each day already.

- Sharon has eyeglasses but does not always wear them. It was initially recommended that she wear them as often as possible. She just started wearing them one year ago. During her last eye appointment on 12/30/03, there were no concerns or recommendations noted, her eyeglass prescription was adjusted slightly. Sharon just needs simple reminders when she is browsing through books or magazines, watching TV or going to the movies to wear her glasses. Also remind her that she helps her eyes to stay healthy when she wears them.

- Sharon takes the following medications: Depakote 250 mg for seizures although no seizure activity has been observed for at least 1 year. Staff continues to monitor and document as needed. Sharon also takes a Multivitamin daily and Colace (stool softener) 1 time per day, as needed. Sharon sometimes has problems with constipation. Her doctor says she just needs to watch what she eats such as adding more foods with fiber. Sharon is not on a special diet.

- Sharon's immunizations such as Hep B and her TB are current.

Example 8C: "What do we need to know or do to support the person (to stay safe)?"
Sharon's personal plan

- Sharon is not always safe when she is cooking in the kitchen. Sharon often becomes forgetful when working in the kitchen, or when a pot is on the stove. Sharon requires supervision when using kitchen appliances such as the stove or oven. (Sharon can use her toaster and microwave on her own). Supervision is required in the kitchen anytime Sharon attempts to prepare a snack, or her lunch for work, etc.
- Sharon often wants to cook a meal using the stove on her own at any given time. Sharon needs constant reminders about the importance of using the stove and oven safely.
- It is important to explain that part of learning requires staying safe and that this will help prevent to fires.
- It is important to know that 6 months ago a small kitchen fire was the result of staff forgetting to supervise Sharon while cooking dinner. (This will be an on-going support need and an outcome to reflect learning safety).

Example 9: Requirements of family of a minor or guardian

Sharon's personal plan

What's important to Sharon's guardian (Carrie?)

- Make sure Sharon lives in a safe neighborhood and shares her home with someone who is compatible such as her current housemate

- To be notified anytime there are issues or concerns. Although Sharon has been fairly healthy, Carrie wants to be sure she is notified of all doctor recommendations or any medication changes. Carrie says a simple phone call, or note will do. Carrie can also be contacted on her cell phone; the QMRP and Service coordinator has access to this number.

- Carrie requests that Sharon's siblings are also invited to the annual meeting. Carrie requests to be notified about all other meeting such as addendums, or monthly meetings. She will do her best to work within her personal work schedule to attend. Advance warning (at least 48 hours) helps her to work out her schedule.

- Carrie states she will notify Sharon's dad so that he too could participate, however, he is usually not available.

- Carrie requests that staff supervise Sharon at all times when using appliances in the kitchen due to an emergency call several months ago resulting in a small kitchen fire. Carrie supports Sharon learning independence in the kitchen but wants to be sure Sharon is safe at all times. She requests to be informed of Sharon's progress towards learning safety skills and what to do in an emergency.

- Carrie requests that Sharon's plan emphasize learning safety skills and that NO ONE STAFF PERSON decides when it is safe for Sharon to cook on her own, but to instead make sure it is agreed upon as a TEAM DECISION.

- Carrie requests to be notified for any and all changes to the person-centered plan. Addendums are not to occur without her prior approval.

Personal Profile:

COMMUNICATION

THE IMPORTANCE OF COMMUNICATION:

Missouri Quality Outcome #5: "People's communication is understood and receives a response".

Missouri Quality Outcome #6: "People are provided behavioral supports in positive ways".

To support others in learning skills of self-determination, individuals must be well grounded in listening to and understanding human behavior. Comprehending the underlying functions of human behavior is critical to being able to adequately understand others. It must be understood that all human behavior is purposeful and goal-oriented, although the purpose(s) or goal(s) of each behavior may not be readily perceived. Actually, it is quite easy to misperceive another's purpose or goal. Understanding the many factors which influence human behavior and the way that behavior generally tends to present itself will guide one into greater understanding of others. The learner can begin to "listen" not only to words and body language, but to the actual behaviors engaged in for the "message" behind those behaviors. (Missouri Community Network Curriculum- May, 2001)

We all need a reason to communicate. Most individuals express ideas, feelings and desires through words, gestures and body language to convey messages and respond to others in their environment. A person must be able to understand what is being communicated and a means of communicating back is also needed. This may require training in language acquisition and/or in the use of an augmentative communication device. Individuals' environment should promote the desire for conversation.

Some individuals have difficulty communicating, therefore behavior can often inform us how they are feeling or thinking. Alternative methods for communication should be available in all environmental settings. We should always ask questions about what each person's behavior may be communicating.

When unacceptable interactions occur, attempts should be made to understand the person in terms of communicative intent/function and the variables that are contributing to its presence.

Person-centered planning is a process that promotes learning and understanding a person's individualized support needs so that personal life goals are achieved.

Example 10A: What is important – Understanding how the person communicates using the "communication chart"
Chart format - Kate's personal plan

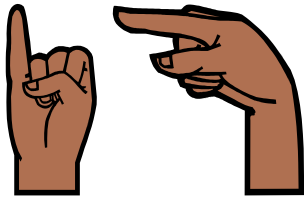
How "Kate" Communicates

What is happening…	Kate does this…	We think it means…	And we should…
Kate is in emergency room or doctor's office	Hits, grabs, flings arms and legs about	Kate is scared	• Give Kate paper to play with • Read and show pictures in magazine
Kate is walking with support	Sits downs	• Kate doesn't want to go where you are taking her • Kate is afraid of falling • Kate is tired-back hurts	• Ask her to show you where she wants to go • Hold her more securely under her arm • Sit down with her for a rest
Kate is sitting in a chair	Gets down on floor and lies down	Kate back is tired of sitting up	• Support her to walk around a bit • Find an appropriate place for her to lie down awhile
Kate is eating	• Turns her head to the side • Hands you her spoon • Makes "The Mouth"	• Wants no more food • Feed me • I need to burp	• Put the food away • Wait until she has burped or belched before she eats more
Kate is out shopping, eating in restaurant, or is in any place where there are people her age	Has a smile on her face and reaches out to touch the arm or take the hand of a young woman Acts flirty, giggly, or coy around a young man	Hello, I want to spend some time with you I like your looks! Want to be friends?	If possible, say "hi" to the person and introduce Kate Same as above

Example 10B: Chart format – Sharon's personal plan

When this is happening…..	Sharon does this….	We think it means…	And we should……..
At any time	Points to her pictures	Sharon wants you to look at her pictures	• Take a few minutes to look at her pictures • Ask questions, Sharon can say, "yes/ no"
Usually at bedtime	Starts crying and shows no interest in interacting	She is sad and misses her mom	• Try encouraging Sharon to look at pictures of her mom and talk to her • Call her mom (she has given permission to call her at any time Sharon or staff needs to speak with her)
In a setting where there a lots of people	Yells: "lee now" Meaning "leave now"	The environment is a little too crowded for Sharon at that time	• Talk to Sharon, say: "ok we will leave now" (don't try to talk her into staying longer). Say: • "Sharon, may I look at some of your pictures?" Then talk about the pictures while preparing to leave immediately or as soon as possible.

Example 10C: What is important – "How the person communicates" – continued

Anne's communication style: 

- Anne had a communication device that she no longer uses because it is large and cumbersome. She showed no interest in using the device due to its size, and difficulty in programming it. The device was used when she was in school, and required repairs.
- It is documented that Anne once used American Sign Language while in school, but forgot many signs or chooses to no longer use sign language.
- Staff is still learning about Anne's communication style and may need to make guesses before getting it right.
- Anne now has a communication book with photos of favorite people and places. She is encouraged to use it as often as possible. It is also observed that Anne does not appear to like using any device to communicate. It is believed that Anne prefers to use words to communicate although it is not always easy to understand the few words she uses. Sometimes Anne prefers NOT to talk at all!
- Anne will usually respond to yes / no questions by nodding her head. She also understands simple signs and may sign the word "no". Anne also uses the sign for "bathroom", and signs "go" when she wants to go places.
- Anne may also "grunt" when answering a yes or no question.
- Anne may also pull or "tug" on a person's arm to communicate a need.
- When Anne is having a bad day, those who know her well say her forehead "wrinkles", therefore, looking as if she is "shutting down." If this occurs, try offering Anne a snack, or distract her with something she enjoys such as a video, card game, sitting on her porch rocker, weather permitting.
- Anne may place her fingers or palms over her ears, or pace. It is suspected that she is "hearing voices".
- Anne may also place his palms over his ears when he is tuning out certain people or paces when he is bored or restless.
- When Anne paces, we think it means:

She is either bored and needs to be involved in something that interests her.
It could also mean she wants to go places (i.e. leave the room, or a building, or situation, etc.).

- Anne does not <u>verbally</u> express her needs but she definitely understands what others are saying and enjoys your attention by listening or sitting in on conversations.

Personal Profile:

ISSUES / CONCERNS

Example 11

Issues to be resolved / concerns section:

NOTE: This information can also be effectively conveyed in the "what's important" section, or "what's working/not working" section (also known as what does or does not make sense), or in the person's communication chart, etc. Just remember, if this information is identified in other areas of the plan, it is NOT necessary to repeat in another section of the person's plan.

This section can be used to identify a wide range of issues that have not been resolved and continue to be a struggle for the person, family and team. There may also be situations where people cannot come to an agreement, but do agree to seek to find a resolution. This could also be the place to define behavioral issues or concerns relating to health and safety issues (if not listed in the support section for health and safety).

When identified in the plan there must be an attempt to revisit the issue for resolution. This information can and should come from a variety of perspectives: the person, family / guardian, or staff regarding quality of life and support issues. THIS IS NOT THE PLACE TO LIST AGENCY ISSUES PERTAINING TO MANAGEMENT, PERSONNEL, ETC. The team should also use this information as a basis for gathering MORE information and to brainstorm ways to implement change. This information should lead to a plan of action or future planning (to develop long range goals to address unresolved issues).

The guidelines provide a list of situations in which this section could be helpful, for example:

- The person wants one thing and the guardian wants another. (E.g., the person may wish to move back home, but the family does not want this to happen.)

First, the team needs to develop a shared understanding of the situation. The place to begin may be to gather additional information from the person, family and all others who know and care about the person. A team gathering may be necessary to resolve the issues. The team should be asking questions a means of promoting resolution and action:

1) **Do we understand why Jennifer wants to live with her family?**
2) **Do we understand the issues as to why this is not an option?**
3) **Are there issues between Jennifer and her housemates, staff, etc? that causes her to want change?**
4) **Why Is Jennifer unhappy in her present living situation?**
5) **How can we support Jennifer to make an informed choice?**
6) **What are other alternatives that Jennifer and her family can agree to?**

Once the questions are answered, the action plan then needs to be a means of identifying (with the person, guardian, and the team) where to go from here.

Personal Profile:

ACTION PLANNING
&
THE MISSOURI QUALITY OUTCOMES

Tools:

- **What does / does not make sense, or what's working / not working?**
- **What needs to be maintained, changed, and/or enhanced?**
- **Looking at issues / concerns**
- **Valued roles**
- **Transitions**
- **Career outcomes**
- **Vision for the future**

A word about ACTION PLANNING:

Overview:
The decision making we make in our own lives often results in a plan of action. This only means we too make plans, short and long term, to achieve an important goal. We may also need to take "baby steps" before we reach each goal and we may even need a support strategy along the way.

Far too often, promises are made to the people we support with little follow through. Plans are developed, we write it down, but then, it's like the clock stops ticking. Somehow the rest of us move on but the person keeps waiting, and waiting and waiting for change.

Action planning is not a new process because we use it in our own lives, perhaps informally. It ties back to what is important in our lives. By formalizing this process in our work, we must take the time to ensure that no matter who supports the person, the efforts should never stop and the person should not have to wait on us to catch up when he/she has been waiting, waiting, and waiting for quite some time for things to change. Development of the action plan means *commitment, consistency, accountability, and implementation* to reflect all the hours of listening, learning and understanding the person's needs, wants, desires, interests, preferences and capacities.

- *Commitment* = to gather information, to have a shared vision, decision making as a team effort, a promise to make the plan happen.
- *Consistency* = no matter who, when, or where supports are provided, the action plan will ensure supports / services are delivered in a consistent manner, information will not get lost and outcomes are implemented in a way that makes sense to and for the person's needs.
- *Accountability* = responsible person(s) for making sure the outcomes are happening in the person's life.
- *Implementation* = synthesizing the information gathered, putting the plan into action, tracking progress, assessing what does or does not work, an on-going cycle of listening and learning about the person.

Using the Missouri Quality Outcomes to develop outcomes in the person-centered plan:

Plans must be written in accordance with the Missouri Quality Outcomes to ensure opportunities for quality of life. They reflect best practice, and provide us with a look at outcomes that define a typical lifestyle desired by anyone. Although the outcomes provide us with examples of how they can be defined, the definitions are NOT standard. We all could have the same outcome, but may define it differently depending on our current situation, life experiences, and future goals. The steps each of us takes to reach the same outcome may be distinct by our own personalized paths or journeys. For example, the Missouri Quality Outcome that states: "People belong to their community" will be defined differently for you depending on where you live, who you know, what you want from the community, what you want to contribute to your community, and the resources available to access your community.

By using the Missouri Quality Outcomes in the process of person-centered planning will assist the person and his/her team to seek ways to enhance and/or offer opportunities for a better community life, to develop valued roles and to implement action and outcomes that makes sense specific to meeting the person's needs and preferences.

Note: When utilizing the Quality Outcomes as a means to develop personal plan outcomes, the plan facilitator must understand the purpose, intent and values of the outcomes in order to successfully facilitate the action planning process. *Please see the Missouri Quality Outcomes introduction section that outlines the general purpose, values and assumptions.*

Example 12A: ACTION PLANNING COMPONENTS:

a) **Outcome statement** – always reflects what is important *to and for* a person, what's working or not for the person, etc.

A few words to describe an outcome include: the result, or the "big picture." Points to remember:

- An outcome IS NOT a service or service definition such as "will receive residential habilitation". The result is not the residential habilitation but **how** this service impacts the person's quality of life.

- An outcome IS NOT a statement for continued services, such as, "will continue to receive 24 hours support from staff", "will continue speech therapy from school"

- An outcome IS NOT the action step. *Services represent action taken as a means of reaching the outcome*. The purpose of *action steps* is to define what it takes to make the outcome a reality!

b) **Criteria** – How do we know when the outcome is accomplished? Criteria simply mean we have the information we need (from staff observation, documentation, and information from the person, family and others' perspective) that tells us the person has met either the outcome as a whole or the specific action step within the outcome. Quality of life goals are often subjective; therefore, good, detailed documentation for each action step is the key to determining outcome or action step completion.

c) **Current situation:** Justifies the need for the outcome. Ask: "Why does the outcome exist?" It is a short statement that justifies the need for the outcome. It is a good opportunity to again, emphasize the need.

d) **Action Steps:** (otherwise known as "objectives"): These are ACTIVITIES used to define each step one must take to reach the outcome. The action step defines the criteria needed to complete the step.

e) **Strategies:** Where there is an action step, there should be a strategy. How would a staff person know how to implement the outcome / action steps without providing them with the strategies for teaching the person, how the person learns best, documentation requirements, etc? This should be the information staff will need to understand agency expectations to implement the person's action step.

f) **Accountability:**

- Names of person(s) responsible: This is up to the team, but there needs to be someone named as the responsible party for the implementation of each action step.

- Timeline for completion: As best practice it should provide the timeline for when the action step will be implemented because all action steps need not implement at the same time. Action steps should only be implemented for the time the person and the team feels it will take to implement and complete. For example, it does not make sense that an action step for obtaining a state ID will take from March 31, 2004 to February 28, 2005. This action step should only take as long as it takes to set up the time and transportation for the person to accomplish this task; maybe 1-2 weeks or less?

Example 12B: ACTION PLANNING

Use **profile** information to assess what needs to be maintained, enhanced, changed or different (also known as what does or does not make sense, or what's working/ not working) to begin developing action.

What Makes Sense	What Doesn't Make Sense
What works? What needs to be maintained/enhanced? (The upside right now.)	**What doesn't work? What needs to change? What must be different? (The downside right now.)**

	What Makes Sense **What works? What needs to be maintained/enhanced? (The upside right now.)**	What Doesn't Make Sense **What doesn't work? What needs to change? What must be different? (The downside right now.)**
from **Sharon's** perspective: **Best Guess**	Having family care about her Having her friend as her housemate Having pictures of family and friends to share with others Having a pet , (socks her cat) Having someone to spend time with AND spending time alone when she wants to Working part time and making some money Listening to music while doing chores	Places where there are crowds of people or NOT being told this may happen Going to the workshop even if it is 2-3 x per week Crying and missing mom so much NOT using her pictures to initiate conversation with others When staff say they don't have time to talk or look at pictures
from **Staff's** perspective:	Sharon's family support Sharon's mom always seems available Having staff who appreciate and respect Sharon's communication Sharon's home, the location and her housemate Pictures, and recliner/rocker seems "calming" Keeping family informed Keeping a busy schedule	Don't understand why in some places crowds of people are a problem and other times it is not Not always sure why Sharon gets "agitated' Sharon's dependence on mom Sharon's abilities outweigh what she actually learns – Capable of more independence (like in the kitchen) and need to utilize Sharon's talents. She is sociable but only socializes with her family and staff, not friends outside of work.

Note: This could also be a place to share the parent/guardian perspective if not identified in other areas of the plan. The following items should /could be addressed in the "what we need to know or do to support Sharon":

- How to support Sharon in the community when there is a potential problem – such as being around "crowds" of people. However, the staff may need to gain a greater understanding of Sharon's support needs by conducting a "functional assessment" to better understand why she responds in a certain way, with certain people at certain times.
- What to do when "we think" Sharon misses her mom, maybe alternatives to calling mom.

The following items should / could be addressed in the action plan:

- Seeking meaningful work
- Facilitating and enhancing communication in a way that makes sense for Sharon
- Learn safety skills in her home so that independence in the kitchen can be enhanced.

Example 12C: ACTION PLANNING, continued

Step #1: Assess what does / does not make sense (what's working or not), which reflects the information from the personal profile; this takes us to step 2. See previous page with example.

Step #2: Developing the outcome and rationale - (Note: the "rationale" is also referred to the "justification" or "current situation")

Quality Outcome: *Sharon's communication is understood and receives a response.*

Sharon's definition of the outcome: *I want to talk to others using my pictures.*

Current Situation: *Sharon currently uses few words to communicate and is usually understood by staff. Sharon wants and needs a way to communicate with people she does not know especially if she obtains a new job. Sharon likes to use her pictures to initiate conversation with others this is her communication style.*

These are the services that will help to implement the outcome.
Service(s): Residential Habilitation, XYZ Services
Off-Site day Habilitation, XYZ Services

Step 3: Developing Action Steps – (Ask: what needs to happen to make the outcome a reality?)

Step 4: Support Strategies (also known as learning strategies to some).

Action Step #1: Develop a communication book.
Implement by: 4/1/04,
Estimated completion date: 6/1/04
Responsible person(s): Sharon, Kathy (staff), and Justin (QMRP)

Strategies:
- Sharon, with support will develop a list of people, places and things to begin her communication book by 4/15/04. Contact family by 4/5/04 for ideas, go through existing pictures to be used, may need to get extra copies made by 4/10/04.
- Sharon, with support will budget her money to purchase a disposable camera and wallet of her choice to take pictures of her favorite people, places and things by 5/1/04.

Example 12D: ACTION PLAN WORKSHEET USING MISSOURI QUALITY OUTCOMES - **(J. Wyble outcomes trng. – 4/03)**

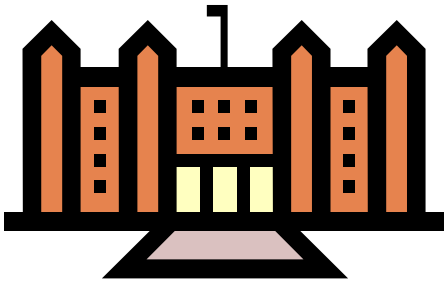
Missouri Quality Outcome:	*Jennifer has a variety of personal relationships.*
Current Situation (Justifies the need for the outcome):	*Jennifer does not see her family as often as she'd like. She hears from her mother and brother by phone and on major holidays. Jennifer, her mom and brother would like more contact but need support to make this happen. Currently, support staff makes informal calls to the family to stay in touch 1 x per month.*
Person's Definition of the outcome (Describes how the person does or would define the outcome)	*I need to talk to my family more often.*
Service(s) Objective(s): **__X__on-going _____wait list**	*1) Jennifer will receive residential habilitation through XYZ agency, Medicaid Waiver and KCRC.* *2) Jennifer will receive personal spending of 30.00 per month monitored by XYZ agency and KCRC.*

	3) Jennifer will receive day habilitation (on-site, group) for 5 hours per day, 5 days per week and off-site for 1 hour per day, 5 days per week through WYB agency, Medicaid Waiver and KCRC.
How do we know the outcome is accomplished?	➢ *Talking to Jennifer and her staff* ➢ *Feedback from family* ➢ *Documentation (staff logs, calendars, etc.) will show evidence that increased contact, more than 1 time per month, is happening consistently for at least one planning year.* ➢ *Jennifer and her team will determine if Jennifer is satisfied with the increased contact.*

What needs to be done? (Action Steps)	**Strategies for Implementation**	**Who's Responsible?**	**Start / Estimated completion**	
1) Jennifer will learn to keep in touch with her family at least weekly (and at her and her family's) request. ("Keeping in touch" is defined by the strategies that work for Jennifer).	a. Purchase a calling card by 5/1/03 by budgeting personal spending funds. b. Make long distance calls to her mother at least 1 x per week, preferably Fridays after 5 pm and help from family. c. Obtain and/or purchase a calendar and address book to record phone numbers and reminders of days to call.	QMRP – Nancy updated monthly and reviewed by SC during visits. QMRP–Nancy XYZ agency AND QMRP – Donna WYB agency (day hab)	4/1/03 5/2/03 4/15/03	5/1/03 Calls are documented weekly – on-going

Consumers On The Move

From



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